AUTHORIZATION FOR RELEASE OF INFORMATION
AND
ASSIGNMENT OF BENEFITS
FOR MEDICARE PATIENTS

NAME_____ MEDICARE #_____

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Atlantic Orthopaedics, for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable for related services."

I understand that information will be released to:

- Billing department of the physician and/or practice

I understand that my information, under certain circumstances may be released for one of the following reasons:

- Other healthcare professionals in order to coordinate my care or treatment
- Insurance adjuster, if my claim is a work or motor vehicle injury
- Employer, if my claim is related to a work injury
- Attorney, if my claims are in litigation process
- Health insurance carrier, for chart audit reasons, and for claim payments

I understand that my physician and/or his staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and his/her staff and the billing office will maintain the up most respect for privacy. However, I also understand that there physical constraints such as noise and the ability for others to overhear information, and other errors that may occur, which may cause inadvertent dissemination of information, as well as the potential for confidential information, as well as the potential for confidential information to be disclosed after it has been provided to others from the clinical billing office.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

_____ _____
Patient or Guardian Signature Witness

_____ _____
Date Date

A 2ND SIGNATURE IS REQUIRED FOR YOUR SUPPLEMENTAL INSURANCE

Name_____ Policy #_____

Insurance Name_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to my provider of services and/or supplier for any services furnished to me by that the provider of service and/or supplier. I authorize any holder of Medicare information about me to release to my secondary insurer, named above, any information needed to determine these benefits payable for related services.

_____ _____
Signature Patient or Guardian Date