ONE TIME SIGNATURE FOR MEDICARE PATIENTS

Name of Beneficiary ______________________________

Medicare Number ______________________________

I request that payment of authorized medicare benefits be made either to me or on my behalf to Dr. Charles L. Harris for any services furnished me by Dr. Harris. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient ______________________________

Date ______________________________