FRYER DERMATOLOGY, PLLC
210-08 Northern Blvd; Ste 2
Bayside, NY 11361

150 Broadhollow Road; Ste 100
Melville, NY 11747

MEDICARE PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize Fryer Dermatology, PLLC. to release medical or other information to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Fryer Dermatology, PLLC. Regulations pertaining to Medicare assignment of benefits apply.

_____ ____/____/____

Signature as it appears on Medicare card Date

If you have a supplemental (secondary insurance) policy and it is a supplemental policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to _____ (please indicate supplemental carrier's name) any information needed to determine these benefits or the benefits payable for related services.

_____ ____/____/____

Signature as it appears on supplemental card Date