STONE CREEK PSYCHIATRY
7945 Stone Creek Drive, Suite 130
Chanhassen, MN. 55317
(952) 241-4050
(952) 241-4049 (fax)

PRINT NAME HERE: _____

PATIENT'S MEDICARE AUTHORIZATION

PATIENT'S NAME: _____

PATIENT'S MEDICARE NUMBER: _____

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to

_____

for any services furnished me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

_____
Patient's Signature

_____
Date