STANDARD SIGNATURE ON FILE FORM

Name of Patient:_____

Patient's Medicare Number:_____

I request that payment of authorized Medicare benefits be made to either me or on my behalf to Dr. Cynthia Davis for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits for related services. This authorization is valid until and unless revoked by me.

Patient's Signature:_____

Date:_____