INSURANCE AUTHORIZATION

Date _____

I authorize Cedar Valley Medical Specialists, P.C. to release any medical information necessary to process my claim.

_____
(Patient)

I authorize payment of medical benefits to Cedar Valley Medical Specialists, P.C.

_____
(Policy Holder)

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MEDICARE AUTHORIZATION

Date _____

I request that payment of authorized Medicare benefits be made either to me or in my behalf for any services furnished me by Cedar Valley Medical Specialists, P.C. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits for related services.

_____ _____
(Patient) (Medicare Number)