Long Term Authorization

Statement to Permit Payment of Medicare Benefits to Physicians

Name of Patient: _____

Medicare Number:_____

I request that payment of authorized Medicare benefits be made, either to me or on my behalf, for any services furnished me by or in Tacoma/Valley Radiation Oncology Centers, including physician services. 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.

_____

Signature of Patient or legal guardian

_____

Date