SelectSkinMD
160036th Street, Suite B
Vero Beach, FL 32960

SIGNATURE ON FILE

Medicare Beneficiaries

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII and/or Title XIX, of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician(s) services. I understand that I am responsible for my health insurance deductibles and coinsurances.

Print Patient's Name HIC (Medicare#)

Patient's Signature Date