# Medicare Authorization for Signature on File

Name of Patient: _____ Beneficiary #:_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

_____ _____
Signature Date

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE:
I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

_____ _____
Signature Date

Main Street Chiropractic
**Charles L. Lennon III, DC**
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