TURVILLE BAY
MRI & RADIATION ONCOLOGY CENTER

Patient Signature on File for Medicare Claims

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Turville Bay MRI & Radiation Oncology Center for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it.

_____ _____

Patient Signature Date

This form was interpreted to patient by _____

Interpreter Signature Date

Revised 03/2015