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ONE-TIME AUTHORIZATION AGREEMENT

Beneficiary Name _____

Health Insurance # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ALAMANCE EAR, NOSE AND THROAT, LLP for any service furnished by them. 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 payable for related services.

_____
Beneficiary's Signature

*If beneficiary unable to sign, please sign your name and relationship to patient.

_____
Date