**Release of Medical Information to Medicare**

*To show agreement, please type your name, signature, and date.*

I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment: New York Speech & Voice Lab PLLC.

Legal name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client: ELECTRONICALLY SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Payment by Medicare to Provider**

*To show agreement, please type your name, signature, and date.*

I authorize payment of medical benefits to the physician or supplier for services: New York Speech & Voice Lab PLLC.

Legal name of client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client: ELECTRONICALLY SIGNED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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