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**GENERAL, VASCULAR AND LAPAROSCOPIC SURGERY**

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**AUTHORIZATION FOR RELEASE OF HEALTH SERVICES OR**

**TREATMENT INFORMATION**

Insurance authorization and assignment: I request that payment of authorized Medicare/other insurance company benefits be made to either me or on my behalf to Great Lakes Surgical Associates for any services furnished to me by the physician or supplier. I authorize any holder of medical information about me to be released to the health care financing administration and its agents any information needed to determine these benefits of the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/other company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/other insurance company as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare/other insurance company.

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Signature and Date