LIFETIME AUTHORIZATION

PATIENT'S NAME: _____

MEDICARE ID#: _____

I request that payment under the medical insurance program be made either to me or to **Surgical Associates, L.L.P.** on any bills for services furnished to me. I authorize Surgical Associates to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Authorization period:

From: _____ To: _____Lifetime_____

PATIENT'S SIGNATURE: _____

DATE: _____