

**GULF COAST PODIATRY  
FOOT AND ANKLE SURGERY CENTER  
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**LIFETIME MEDICARE B SIGNATURE AUTHORIZATION**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

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Patient Signature

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Print Name