NORTH FORK ORTHOPAEDIC &
SPORTS MEDICINE PLLC
55 SOUND AVENUE
MATTITUCK, NY 11952

Patient's Authorization Signature Form

Blue Shield
"I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to Empire Blue Cross and Blue Shield.

I also authorize Empire Blue Cross and Blue Shield to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of the claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with Empire Blue Cross and Blue Shield including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents and our heirs, executors and administrators."

Medicare Part B
"I request that payment of all authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Patient Name (Print Please)_____

Patient Signature _____

Medicare ID number _____

Today's Date _____