EMPOWER PSYCHIATRY & SLEEP LLC

CONFIDENTIAL PATIENT INFORMATION

I authorize any holder of medical information or other information about me to be released to Medicare and/or Health Care Financing Administration or its intermediaries or carriers, or to the billing agent of this doctor or supplier, any information needed for this or a related Medicare claim and/or my Private Health Insurance 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. I understand that this authorization may be used to release medical information if necessary to process my insurance claims and pay the provider or supplier direct. Also, applies to my private and/or group health insurance as applicable.

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Signature of Patient or Guardian

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Date

**If signed by other than beneficiary, state title or relationship and the reason patient was unable to sign.

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