ONE TIME AUTHORIZATION

Approved Form No: OMB No. 0938-0222

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Dr. David Kingrey / Dr. Jeffrey Boomer / Dr. Finny John / Dr. Jack Klenda for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE

DATE SIGNED

37-260 10/82 Revised (6/11)

Form 514 (2/25)