ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to **Wichita Nephrology Group, P.A.** for any services furnished me by that physician/group. I authorize any holder of 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.

DO NOT MAIL THIS FORM IN — Retain in Patient's File in your office.

_____
Patient's Signature

_____
Date Signed

HCFA
Health Care Financing Administration