MISHKEL HEART & VASCULAR CENTER

1599 NW 9TH AVE #203, BOCA RATON, FL 33486

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under the title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediates or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize to submit a claim to Medicare for payment to me.

I request this authorization also apply to all other insurance.

Signed: ___________________________________

RECORDS RELEASE AUTHORIZATION

I Hereby authorize and request you to please send my complete medical history that us in your possession concerning my illness and/or treatment to:

Mishkel Heart & Vascular Center
1599 NW 9TH AVE #203
Boca Raton, FL 33486
Phone: 561-338-8884
Fax: 561-338-5230

Name:___________________________________

Signature:_______________________________

Date:____________________________________