Southern Retina, LLC

CHARLES L. HARRIS, MD

*State-of-the-art retinal care that's focused on you*

ONE TIME SIGNATURE FOR MEDICARE PATIENTS

Name of Beneficiary _____

Medicare Number _____

I request that payment of authorized medicare benefits be made either to me or on my behalf to Dr. Charles L. Harris for any services furnished me by Dr. Harris. 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.

Signature of Patient _____

Date _____