TWO RIVERS SURGERY CENTER LLC
Two Rivers Surgery Center, LLC
194 Highway 35 ~ Red Bank, NJ 07701
Tel: 732-242-4000 Fax: 732-383-6815

AUTHORIZATION STATEMENTS FOR INSURANCE PROGRAMS

PATIENT NAME: _____

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, authorize the Two Rivers Surgery Center to release to designated third parties such information, as may be necessary, including the diagnosis from the medical records compiled during the facility stay, for the purpose of processing my facility and anesthesia claim. I am aware that the physician performing my procedure/surgery has a financial interest as an owner in Two Rivers Surgery Center, LLC

Patient's signature _____ Date _____ Time _____

AUTHORIZATION TO PAY FACILITY/ANESTHESIOLOGIST DIRECTLY

I hereby authorize payment directly to the Two Rivers Surgery Center and the anesthesiologist of the facility/ anesthesia health insurance benefits otherwise payable to me, but not to exceed the balance of the facility's/ anesthesiologist's regular charges for these services.

Patient's signature _____ Date _____ Time _____

AUTHORIZATION FOR MEDICARE PATIENTS

Patient's Certification-Authorization to release information
Hospital and Medical Insurance Benefit-Social Security Act

I certify that information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Two Rivers Surgery Center and Anesthesiologist to release to the Medicare Bureau, Health Care Financing Administration, or its intermediaries or carriers any information about me needed for this claim including medical information relating to my treatment. Only information needed for the purpose of processing my claim for medical benefits may be released. I further authorize the release of medical and related information about my treatment to the Professional Review Organization for routine auditing of care rendered at the Two Rivers Surgery Center, LLC.

This authorization will expire two years from the date signed; however, I reserve the right to withdraw this authorization at an earlier date.

Patient's signature _____ Date _____ Time _____