

Douglas M. Woseth, M.D., FAAD  
Angela K. Brimhall, D.O., FAOCD, FAAD  
Breton A. Yates, M.D., FAAD  
Elena M. Hadjicharalambous, M.D., FAAD  
Michael R. Swinyer, P.A.-C.  
Alisa Seeberger, F.N.P.  
Shane M. Farr, P.A.-C.

RELEASE OF INFORMATION


I authorize any holder of medical or other information about me to release to the Society Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in placed of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Date of Birth

  
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Douglas M. Woseth, M.D., FAAD  
Woseth Dermatology, P.C.