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### **Lifetime Medicare Authorization**

I request that payment of authorized Medicare Benefits be made to GEM STATE DERMATOLOGY, P.A. on my behalf, for any services furnished by my physician and/or physician assistant at Gem State Dermatology. I authorize any holder of medical information regarding my medical records and medical history to release to the Centers for Medicare and Medicaid Services (CMS) and their agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Patient Signature

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

\_\_\_\_\_  
Today's Date