

N. Scott Ferguson, O.D.  
479 Main Street  
Fryeburg, ME 04037

207-935-3307 / FAX 207-935-4002

**LIFETIME COMMERCIAL INSURANCE AUTHORIZATION**

Provider Name : N. Scott Ferguson, O.D. \_\_\_\_\_  
Insurance Company

I authorize the release of any medical information necessary to process claims for myself.

I also authorize payments under my insurance programs to be made directly to the above provider for any services furnished to me.

This authorization also permits the release of information by HCFA (its intermediaries or carriers) on any UNASSIGNED Medicare claims to the above.

I further permit copies of the authorization to be used in place of the original.

\_\_\_\_\_  
Patient Signature (or responsible party)

\_\_\_\_\_  
PRINT Patient Name (or responsible Party)

\_\_\_\_\_  
Date