CHRIS M. PETRAS, M.D.
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I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Chris M. Petras for any services furnished by that physician. 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 Date

I request that payment of authorized supplemental insurance benefits be made either to me or on my behalf to Dr. Chris M. Petras for any services furnished me by that physician. I authorize any holder of medical information about me to release to my supplemental insurer any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature Date