Windward Urology Associates Ltd
Ellerslie School Road, Black Road
St. Michael, Barbados
Tel: (246) 426-5078 - Fax: (246) 426-5079
JOHN ROLAND FRANKLIN, M.D., M.A.
DIPLOMATE, AMERICAN BOARD OF UROLOGY
2-YEAR FELLOWSHIP IN UROLOGIC ONCOLOGY

9003 HAVENSIGHT, STE 301
St. Thomas USVI 00802
Ph: 340-774-9655
Fax: 340-774-9646

20 GOLDEN ROCK STE 102
St Croix, USVI 00820
Ph: 340-719-7830
Fax: 340-719-7834

5 DOCTORS MEDICAL WELLNESS SERVICES
Unit 13, Fisher's lane, Tortola, BVI
Ph: 284-494-6757
Fax: 284-494-6897

INSURANCE RELEASE INFORMATION FORM

Please read and sign the release agreement below. If you only have private insurance, you need not fill out the Medicare section. If you have both Medicare and a supplemental insurance, you must sign and fill out both sections. If you only have Medicare insurance, only fill out the Medicare section of this form.

PRIVATE INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned have insurance with_____ insurance company (ies). I hereby assign directly to Dr. Franklin all medical benefits, if any, payable to me for any services rendered. I further authorize the release of any medical information necessary to process my insurance claim. In addition, I also authorize the use of this signature on all my insurance submissions. I also agree that a photocopy of this form may be used in lieu of the original. This authorization will cover all material services rendered, until this authorization is revoked in writing.

Signature of Insured: _____
Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorization Medicare benefits be made on my behalf to Dr. John Roland Franklin for all services which Dr. Franklin has provided me. I request and authorize all holders of medical information about me to release to the Health Care Financing Administration and its agents and all information necessary to determine these benefits or the benefits payable for related services. My signature authorizes that payments be made to Dr. Franklin, and also authorizes the release of all and any information necessary to pay the claim. I also agree that a photocopy of this form may be used in lieu of the original. If "other health insurance" is indicated on item 9 of the HCFA-1500 form or elsewhere on other approved claim form, my signature further authorizes releasing of the information to the insurer or agency shown.

Signature of Insured: _____
Date: _____