Consent for Treatment and Release of Medical Information/Medical Records

We will need your authorization indicating your consent for medical procedures and care under the general and specific instructions of the Physician(s) or his designee as is necessary in his judgment. And in order to receive information from other health care professionals or facilities, we need your authorization to have that medical information released to physician(s). In order for us to receive payment from your insurance carrier, we need your authorization to provide the insurance carrier with information regarding the care you have received.

Assignment of Benefits/Insurance Requirements

We request you to assign and transfer all rights, title and interest in all benefits/monies payable to the Physician(s) at Texas Specialist Center.

Financial Responsibility

In consideration of the services rendered, you hereby agree to pay for the total charges incurred regardless of any or all assigned benefits/monies. You further agree that should your account become delinquent, you will be responsible for all reasonable attorney or collection agency fees.

Acknowledgement of Review of Notice of Privacy Practice

I am aware of this office's Notice of Privacy Practices. It explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Patient's Name **(PRINT)** Date of Birth

_____

Name of Parent/Personal Representative (anyone you would not mind getting information, i.e. Appointment info, test results, surgery info.)

_____

Relationship to Personal Representative's Authority (spouse, child, relative, ect.)

I have read and understand the above._____

Patient or Guardian Signature Date

Witness _____