UT MEDICINE SAN ANTONIO
UT HEALTH SCIENCE CENTER™
WE MAKE LIVES BETTER

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS, CONSENT FOR TREATMENT, AND ASSIGNMENT OF BENEFITS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Initials _____

I authorize UT Medicine San Antonio to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, continuity of care and medical treatment.

CONSENT FOR TREATMENT

Initials _____

As a consulting adult and/or legal guardian, I agree to permit the physicians and staff of UT Medicine San Antonio to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at UT Medicine San Antonio to perform necessary or appropriate medical care including physical examination, diagnosis, and treatment.

ASSIGNMENT OF BENEFITS

Initials _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to UT Medicine San Antonio. I understand that I am responsible to follow up with insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize UT Medicine San Antonio to release all information necessary to secure payment.

I have read the Authorization Release of Medical Records, Consent for Treatment and Assignment of Benefits.

Patient Name :_____ **Date:**_____

PRINT NAME

Signature of Patient
Or Legal Guardian :_____ **Date:**_____

Relationship to Patient: _____

Witness: _____ **Date:**_____