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

UT Medicine at San Antonio

NOTICE FOR REQUEST OF DISCLOSURE OF SOCIAL SECURITY NUMBER

(Patient Billing and Collections)

Disclosure of your Social Security Number (SSN) is required of you in order for UT Medicine San Antonio to bill and collect for patient services under Medicare or Medicaid. Federal law mandates a social security number is required to obtain benefits under Medicare and Medicaid (42 USC, Section 1320b-7(1)). For commercial insurance, there is no statute or authority that requires that you disclose your SSN. Failure to provide your SSN, however, may cause the insurance company to deny payment for lack of SSN. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information UT Medicine collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have UT Medicine correct information about you that is held by UT Medicine and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UT Medicine at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to UT Medicine HIPAA Compliance
By mail to: 6126 Wurzbach Road San Antonio TX 78238
By e-mail to: UPGPrivacy@UTHSCSA.edu
By fax to: (210) 257-1436
In person at: 6126 Wurzbach Road San Antonio TX 78238

PLEASE KEEP THIS PAGE FOR YOUR RECORDS

UT MEDICINE SAN ANTONIO
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UT Medicine San Antonio
Consent for Disclosure and Acknowledgement of Receipt of Notice for Social Security Number

CONSENT FOR DISCLOSURE OF SOCIAL SECURITY NUMBER FOR PATIENT BILLING AND COLLECTIONS

I hereby consent to the disclosure of my Social Security Number by UT Medicine San Antonio for the stated purpose listed on Notice.

Patient Name (please print): _____

Patient Signature: _____

Date Consent Signed: _____

Acknowledgement of Receipt of Notice of Request for Social Security Number for Patient Billing and Collections

Your name and signature on this sheet indicate that you have received a copy of UT Medicine San Antonio's Notice of Request for Social Security Number on the date indicated. If you have any questions regarding the information in the Notice of Request for Social Security Number for Patient Billing, please do not hesitate to contact the Clinic Manager or the UTM Administrator indicated on your Notice.

Patient Name (please print): _____

Patient Signature: _____

Date Consent Signed: _____

PLEASE SUBMIT THIS PAGE TO THE FRONT DESK