# PATIENT AUTHORIZATION FORM

| RELEASE OF MEDICAL INFORMATION | INITIALS |
|---|---|
| I authorize San Antonio Kidney to release or disclose any protected health information about me to carry out treatment, payment and healthcare operations. | |

| CONSENT OF TREATMENT | INITIALS |
|---|---|
| I authorize the health care providers at San Antonio Kidney to perform a physical examination and provide me (or the patient I represent) any medical treatment deemed necessary. | |

| FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS | INITIALS |
|---|---|
| I understand I am ultimately responsible for payment on my account. I understand it is my responsibility to provide insurance information, to include any changes, to San Antonio Kidney. I understand I am responsible for any referral or authorizations that my insurance may require and for any charges not covered by my insurance, to include co-payments, deductibles and coinsurance. I authorize payment of benefits to be paid directly to San Antonio Kidney. I understand I am financially responsible for any balances and charges not covered by this assignment. | |

| NOTICE OF PRIVACY PRACTICES | INITIALS |
|---|---|
| I acknowledge San Antonio Kidney has provided me a copy of the Notice of Privacy Practices which explains how my Protected Health Information (PHI) may be used and/or disclosed. | |

____________________________________
Print Patient Name

____________________________________ ______________________________
Signature of Patient or Legal Representative Date