PATIENT AUTHORIZATION FORM

RELEASE OF MEDICAL INFORMATION	INITIALS
I authorize San Antonio Kidney Disease Center Physicians Group, PLLC 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 Disease Center Physicians Group, PLLC 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 Disease Center Physicians Group, PLLC. 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 Disease Center Physicians Group, PLLC. 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 Disease Center Physicians Group, PLLC 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.	

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Print Patient Name

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Signature of Patient or Legal Representative Date