Anil Tibrewal, M.D.

Texas Minimally Invasive Surgery Center, PA

2727 Bolton Boone Drive, Suite 108

Desoto, TX 75115

Office (972) 298-4622 Fax (972) 298-4633

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Name of Patient: _____ ("Patient")

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security Number: _____ Account Number: _____

Date of Last Visit: _____ Physician Seen: _____

1. I authorize the use or disclosure of the Patient's health information, as described below.

2. The following individual's or organizations are authorized to make the disclosure:

   [ ] **Texas Minimally Invasive Surgery Center, PA**

3. The type and amount of information to be used or disclosed is as follows: (Please Check)

___ Entire Health Record	___ Operative Procedures	___ Pathology Report
___ History & Physical	___ X-ray/Imaging Reports	___ X-ray Film
___ Echocardiogram	___ Laboratory Reports	___ Biopsy Slide(s)

4. I understand that the information in the Patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual(s) or organization(s):

   Name: _____

   Address: _____

6. This information is being disclosed for the following purpose(s); _____

_____

7. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Texas Minimally Invasive Surgery Center, PA (TMISC). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

8. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing.

9. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

10. I understand that I will be given a copy of this authorization form, after signing.

_____ _____

Signature of Patient/Responsible Party or Legal Representative Date

_____ _____

If Signed by Legal Representative, Relation to Patient Date

_____ _____

Signature of Witness Date

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1. Authorization to Release Information:

I authorize Texas Minimally Invasive Surgery Center, PA (TMISC) to furnish requested information from the patient's medical and other records to: (1) any insurance company or third party payor for the purpose of obtaining payment on account of TMISC, (2) any other person(s) or entities financially responsible for the patient's care or treatment, and (3) representatives of local, state, or federal agencies in accordance with law. Such information may include, but is not limited to, information concerning communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS"). I authorize the release of information from or the review of the patient's records for purposes of conducting medical audits, utilization reviews, or quality assurance reviews.

2. Assignment of Benefits:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

If this account is assigned to an attorney for collection and or suit, the prevailing party shall be entitled to reasonable attorney's fees for costs of collection.

I understand that I am responsible for providing TMISC all insurance information at the time of registration to allow for verification of benefits, and that regardless of my assigned insurance benefits, I am responsible for the total charges for services rendered.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to TMISC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

3. Medicare / Medicaid Assignment of Benefits:

a. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize the release of information concerning me to the Social Security Administration or its intermediaries or carriers as well as any information needed for filing a Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable for services to the physician or organization submitting a claim to Medicare for me.

Initial _____

b. I understand that Medicaid recipients are responsible for payment of any medical care or service received that is beyond the amount, duration and/or scope of the Texas Medicaid Program, as determined by the Medicaid Department or its health insuring agency. All payments for non-covered services are due and payable at the conclusion of each office visit unless prior payment arrangements have been made.

Initial _____

_____ _____

Signature (and relationship if not patient) Date

[ ] Patient under 18 years of age

_____

Witness

_____ _____

Translator (Print Name) Translator (Signature)