VEGA SURGICAL GROUP

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AUTHORIZATIONS

Authorization to Release Health Care Information

In order to enable effective evaluation, diagnosis or treatment of my medical condition or medical condition of my dependent, I hereby request and authorize the release of the medical records of the patient named below.

Patient's name: _____

Date of Birth: _____

Social Security Number: _____

I request and authorize _____ (Name of Healthcare Provider) to release the medical records of the patient to:

Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group
Dr. Lixana Vega Vega
950 Threadneedle, Suite 140
Houston, Texas 77079-2903

This request and authorization applies to:

___ All records ___ Discharge/ Consult Notes ___ Imaging Results (Ultrasound/CT/MRI)
___ER Records ___ Other

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS VIRUS), sexually transmitted diseases, psychiatric disorders/ mental health, or drugs and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

_____ _____ _____
Signature of Patient or Patient's Authorized Representative Print Name Date

AUTHORIZATIONS

Consent for Medical Treatment:

I hereby authorize Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group PLLC, to render any and all treatment my physician or other care providers deem necessary in connection with the evaluation, diagnosis, or treatment of my medical condition or the evaluation, diagnosis, or treatment of my dependent named below.

To the best of my knowledge, I have answered the questions on this form, any other forms provided by Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group PLLC, and any inquiries made by my physician or any of my care providers accurately. I understand that providing incorrect information can be dangerous to my health or the health of my dependent. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status or the medical status of my dependent.

Assignment of Benefits:

I authorize direct payment of all insurance benefits, including Medicare, to Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group, for all medical services rendered to me during the course of treatment provided by Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group PLLC. I understand and agree this assignment of benefits will have continuing effect for so long as I am being treated or cared for by Lixana Vega Vega, MD, PLLC, d/b/a Vega Surgical Group PLLC. I also understand that I am responsible for any portion of my bill not covered by my insurance company.

Patient Name _____ Date _____

Name of Insured Party_____ Signature of Insured Party_____