COVID Infusion Center

A Division of Wilson Medical

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the patient to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR INSURANCE CLAIMS

I hereby authorize the physician(s) to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of the physician's charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider organizations, welfare funds, the Social Security Administration or its intermediaries or carriers. **I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release TPG, its agents and it employees from liability in connection with the release of the information contained therein.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit. I understand I am financially responsible for charges not covered by this assignment.

I understand a photocopy of this document is as valid as the original.

Print Name _____

_____ Date:_____

Patient's Signature

_____ Date:_____

OR Responsible Party Signature (parent of minor, etc)