



AUTHORIZATION TO PERFORM EXAMINATION(S) FOR DIAGNOSTIC PURPOSES

I hereby authorize Baptist M&S Imaging (V.H.S. San Antonio Imaging Partners, LP) to perform the examination(s) ordered by my physician for diagnostic purposes. I further understand that only my physician can inform me of the results of said examination(s). If executing this document on behalf of the patient, I certify that I have the authority to do so.

MEDICAL RELEASE/ASSIGNMENT OF BENEFITS

I hereby authorize payment of all health insurance benefits to Baptist M&S Imaging and allow assignee to release all information necessary to secure payment. I agree that a photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am legally responsible for all charges incurred whether or not they are paid by my health insurance, and that any unpaid balance shall be due in full IMMEDIATELY if insurance proceeds are paid directly to me. I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians as deemed necessary.

ACKNOWLEDGEMENT – RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the provider's Notice of Privacy Practices.