



GENERAL CONSENT FORM

This consent applies to all University of Texas Health Science Center at San Antonio (UTHSCSA) entities to include but not limited to: UT Health San Antonio-Physicians, UT Health - Cancer Center, and UT Health - Nursing.

Consent for Treatment

As a consenting adult and/or legal guardian, I permit the physicians, staff, residents or affiliates of UTHSCSA to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I permit the physician, staff, residents and affiliates of UTHSCSA to perform necessary or appropriate medical care and care coordination services, including, but not limited to: physical examination, diagnosis, treatment and medication reconciliation.

Authorization for Receipt/ Release of Medical Records

I authorize UTHSCSA to receive, request, use and disclose my medical information for the purpose of treatment, payment and healthcare operations.

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, any other health plans or other funding sources, to UTHSCSA. I understand that I am responsible to follow up with my insurance/funding source due to any discrepancy in coverage/payment. I understand I am financially responsible for all charges whether or not paid by my insurance, health plan or funding source.

Consent for Communication

I consent to receiving auto-dialed and/or artificial (Interactive Voice Response Call) or pre-recorded message calls or texts to my cellular telephone, my land line telephone number, or e-mail address provided during my registration process from the clinic or its Business Associates acting on its behalf.

Patient Name: _____ Date: _____

PRINT

Signature of Patient
Or Legal Guardian: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____