Authorization and Consent for Medical Treatment:

I consent to treatment as deemed necessary and appropriate **by Rafael A. Rodriguez, M.D.**

Consent for Use and Disclosure of Health Information for Treatment, Payment and Operations. **By signing below**, I consent to the use and disclosure of my protected health information by **Rafael A. Rodriguez, M.D.**, its staff and business associates for the purposes of treatment, payment and health care operations. My protected health information includes any information that reasonably identifies me and relates (1) to the provision of healthcare to me, (2) to any of my past, present or future health conditions, or (3) to the past, present or future payment for any provision of healthcare to me. The information that is protected includes information related to my physical or mental health. I understand that I have the right to request that Rafael A. Rodriguez, M.D. restrict its uses and disclosures of my protected health information that Rafael A. Rodriguez, M.D is otherwise permitted to make for treatment, payment and health care operations. Rafael A. Rodriguez, M.D however, is not required to agree to these restrictions. Nevertheless, if Rafael A. Rodriguez, M.D agrees to any restrictions, those restrictions are binding on it. Finally, I understand that I have the right to revoke this consent in writing, except to the extent that Rafael A. Rodriguez, M.D has acted in reliance on it.

Assignment of Benefits and Appointed Representative. I certify that the information I have given to Rafael A. Rodriguez, M.D is true and correct to the best of my knowledge. I promise to pay to Rafael A. Rodriguez, M.D all charges and expenses for services provided to me by Rafael A. Rodriguez, M.D in accordance with its current fees and charges to the extent that those fees and charges are not covered or paid by my insurance or by another payment source such as Medicare or Medicaid. I request that payment of authorized benefits under any private or government insurance program that covers me, including the Medicare program, be made on my behalf to Rafael A. Rodriguez, M.D for any services furnished to me by Rafael A. Rodriguez, M.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine my Medicare benefits, if any, for services furnished by Rafael A. Rodriguez, M.D. may pursue collection of benefits in my name or in the name of Rafael A. Rodriguez, M.D as my appointed representative and agent. I also authorize the use of a copy of this authorization in place of the original. I understand that possession of medical insurance does not relieve me of financial responsibility to Rafael A. Rodriguez, M.D. I will personally be responsible for all charges for services that are not covered by my health insurance provider.

Date ______________________ Signature ______________________

Date ______________________ Witness ______________________

This Authorization must be signed by the patient, a parent of a minor, or guardian if the patient is incapacitated.