Ortho El Paso

Jason Vourazeris, M.D./Justin S. Mitchell, D.O. reserve the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for **Ortho El Paso/ Precision Hand Surgery Center**

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Name of Patient (Print or Type) DOB

AUTHORIZATION:
I hearby consent to any necessary medical treatment for myself or the minor child named above for whom I am legally responsible.
ASSIGNMENT:
I permit payment directly to Ortho El Paso and Jason Vourazeris, M.D. or Justin S. Mitchell, D.O., for any benefits due for services rendered. I understand that I am responsible for all charges, whether or not covered by my insurance company.
MEDICAL RECORDS:
Authorization is hereby granted for release of any information required to process insurance claims. A copy of this authorization is as valid as the original. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

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Signature of Patient

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Signature of Patient Representative
(Required if the patient is a minor or adult who is unable to sign the form)

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Relationship of Patient Representative to patient

_____

Date