Star Urology of Texas, P.A.

3112 W. Hwy 22

Corsicana, TX 75110

New managed care insurance regulations require all patients sign treatment release forms.

This release will become part of the patient’s medical record. If you have already signed the form, please return it to the receptionist.

* I consent to treatment necessary for the care of the patient indicated below.

Authorization is hereby granted to release information as may be necessary to process and complete any insurance claims.

Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to treat/07/2015