Consent to Disclosure of Medical Information

I understand that health care services received by me or my family through Dr. Clanton may be covered by one of more health insurance policies or other health plans.

I understand that in providing or arranging these health care services, Dr. Clanton will learn personal medical information about me or my family.

I agree in behalf of myself (and, if applicable, any minor child named on this form) that Dr. Clanton may share all medical information with the health plan(s) and that the health plan(s) may share all medical information with other persons, including any information concerning diagnosis or treatment of mental disorders or alcohol or drug abuse. However, my agreement is limited to the extent that the sharing of medical information is reasonably necessary for the administration of the health plan(s), including all procedures for quality and cost efficiency.

I, the undersigned, hereby authorize the release of medical records or medical documentation (history/physical examination, progress reports, radiology reports and surgery reports to:

Elizabeth Clanton, MD
Pediatric & Adult Plastic & Reconstructive Surgery
11842 Wurzbach
San Antonio, TX 78230
P (210)460-7632 F (210)591-1192

In consideration of services rendered, I hereby transfer and assign all right of payment due to me for medical and or surgical services under any polices of insurance.

_____ _____

Print Patient's Name Social Security Number

_____ _____

Signature of Patient or Guardian Date