Patheous HEALTH
formerly known as DiagnosTEX

AUTHORIZATION TO EVALUATE / RELEASE OF INFORMATION

Patient Name: _____ HIC: _____

Ordering physician: _____

TO: DiagnosTEX Consultants, PLLC, a wholly owned subsidiary of Patheous Medical, PLLC. I hereby authorize DiagnosTEX Consultants, PLLC to evaluate me under the plan of treatment as authorized by my physician(s). This evaluation may include any one or all of the following procedures as indicated: a modified barium swallowing function study to determine the presence of dysphagia in the oral and pharyngeal stages as well as thoracic esophagus and cervical spine assessment.

TO: _____ (Facility name), I hereby authorize you to release any medical records in your possession concerning my illness and/or treatment to DiagnosTEX Consultants, PLLC as requested.

TO: _____ (Patient's Primary Physician's Name), I hereby authorize you to release any medical records in your possession concerning my illness and/or treatment to DiagnosTEX Consultants, PLLC as requested.

TO: Social Security Administration: I hereby authorize you to verify the correctness of my Medicare Number and/or birth date as requested by DiagnosTEX Consultants, PLLC.

TO: DiagnosTEX Consultants, PLLC I hereby authorize the above agency to release any medical records in its possession concerning my illness and/or evaluations to physicians, hospitals, nursing homes, or other medical agencies or institutions as necessary. I hereby authorize that information of my evaluation may be used for educational purposes. In these cases, DiagnosTEX Consultants, PLLC will take steps to protect my privacy.

TO: DiagnosTEX Consultants, PLLC I hereby authorize payment to DiagnosTEX Consultants, PLLC for the benefits otherwise payable to me but not to exceed the balance due of the agency's regular charges for these services. I understand I am financially responsible to this Agency for charges not covered by this authorization.

TO: Medicare: Patient's Certification: Authorization to release information and payment request, I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

TO: _____ (Insurance Carrier), I hereby authorize the release of all information required to act on this request. I request that payment of authorized benefits be made in my behalf for the above services rendered by DiagnosTEX Consultants, PLLC.

Signed: _____ Date: _____ Witness: _____
Patient's Signature

Signed: _____ Date: _____ Witness: _____
Responsible Party or Guardian

Relationship: _____ Patient unable to sign. Date: _____ Witness: _____

*Verbal Authorization **given** by: _____ Relationship to patient: _____

*Verbal Authorization **taken** by: _____ Date: _____

* Verbal authorization may be taken by phone, and the responsible party must sign the document upon the next visit to the facility. A copy of the signed form should be faxed or emailed to the appropriate **PATHEOUS HEALTH** scheduling office once completed.

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1. For patients seen at home or in Assisted Living: A travel fee of $30.00 is due before or upon arrival.
2. If DiagnosTEX arrives for a scheduled appointment and the patient either to participate or is unable to be transported to our mobile clinic, a fee of $190.00 may be assessed.

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Please initial here