

**LEE V. ANSELL, M.D., PA
CLINIC ENCOUNTER RECORD**

I. AUTHORIZATION FOR TREATMENT

I, (or We) hereby grant permission to authorize and direct the authorities of Lee V. Ansell, M.D.PA to perform such medical and/or surgical procedures on me (him or her) as they deem in their judgment advisable or necessary for the treatment or care of (1) any conditions now recognized or contemplated, and (2) any conditions, not now recognized or contemplated, which are revealed or arise during the course of such treatment or care.

I, (or We) acknowledge that no warranty or guaranty has been made as to the results that may be obtained from such treatment and care, that I (or we) understand the nature and purpose of the above authorized treatment, and that I (or we) have fully informed myself (ourselves) or the contents and effects of the above Consent and Authorization, and do hereby freely give my (our) consent thereto.

Signed _____ Witness _____
Date Patient

Signed _____
Nearest Relative, Legal Guardian or other person Relationship to patient
authorized to consent for patient.

II. ASSIGNMENT OF BENEFITS TO LEE V. ANSELL, M.D. PA

I certify that the information given by me is true and correct to the best of my knowledge and promise to pay Lee V. Ansell, M.D. PA, all charges for the above patient in accordance with the regular tariffs of the Hospital and/or Lee V. Ansell, M.D.PA that are not covered or payable by this assignment. I hereby authorize payment to Lee V. Ansell, M.D.PA the benefits payable to me. In applying for payment under the Title XVII of the Social Security Act, I request payment of authorized benefits by made on my behalf to those who accept this assignment. I hereby authorize the use of a photographic reproduction of this authorization in place of the original

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any holder of medical information about me to release to my insurance carrier or sponsoring agency or the Social Security Administration or its intermediaries or carriers, when relevant, information requested by them and needed for processing of any benefit claim

Signed _____
Date Patient

III. AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ hereby authorize Lee V. Ansell, M.D. PA to
release a copy of my treatment record for the (date) _____
to _____
Physician or institution

Signed _____ Witness _____
Date Patient

**DR. ANSELL HAS AN OWNERSHIP INTEREST IN FOUNDATION SURGICAL HOSPITAL
AND ALSO HAS PRIVILEGES AT MEMORIAL HERMANN SOUTHWEST HOSPITAL.**