Lone Star Physicians Group, P.A.

HIPPA policy acknowledgement and Insurance Benefits and Information Release

I hereby acknowledge that I have read the HIPPA policies and received a copy (if requested) for Lone Star Physicians Group, P.A.

Also, I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

Signature of the parent/guardian	Date

Parent/Guardian's Name

Child/patient Name:

Child's date of birth:

Authorization to Treat Minor

As the parent/guardian of the above-named child, I hereby give permission to Iresh Kumar, MD to treat my child in the event that a medical emergency arises and I am unable to personally consent to the treatment. I also agree to be responsible to the physician for charges for medical services rendered.

Signature of the parent/guardian	Date

Parent/Guardian's Name