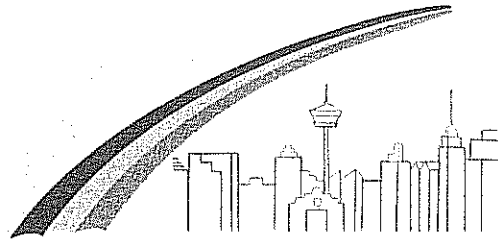


2020 BABCOCK RD., SUITE 19
SAN ANTONIO, TEXAS 78229-4440
Telephone (210) 614-5000



RAYMOND RUENES, M.D.
JOSÉ A. CÁRDENAS, M.D.
CARMEN T. GARZA, M.D.

MEDICAL CENTER PEDIATRICS

APPOINTMENT OF AUTHORIZED REPRESENTATIVE FORM

INSURED NAME

INSURED ID NUMBER

I, _____, appoint MEDICAL CENTER PEDIATRICS, authorized representative, in connection with any claim for coverage or benefits identified in case # _____ including receipt of any approval(s) or authorization(s) that are required before medical service(s). I authorize my representative to receive any and all information related to this case that is provided to me, and to act for me and for my minor dependent, if named above, in providing any information to the group health plan in relation to the disputed claims, approvals, or authorizations. This document is not intended to authorize access to any personal health information unrelated to the disputed claims, approvals, or authorizations.

SIGNATURE OF INSURED

DATE

Address: _____

Telephone Number: _____

I, Raymond Ruenes, MD, hereby accept the above appointment. I am the medical physician for the insured's dependents.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

Address: 2020 Babcock Rd, Suite 19
San Antonio, Texas 78229-4440

Telephone Number: 210-614-5000