



**AUTHORIZATION TO TREAT AND CONSENT TO FILE INSURANCE**

I give my permission for medical treatment by Paige C. White, MD or by order of Dr. White. I consent to the release of medical records to file my insurance on my behalf to our clearinghouse and directly to my insurance and have said benefits sent to The Urology Clinic, LLC. This authorization can be revoked by me at anytime in writing to the clinic.

**GOVERNING LAW AND VENUE**

The validity, construction and interpretation of this Agreement and any exhibit shall be governed by the laws of the State of Mississippi (without regard to Mississippi's conflicts of laws). The parties hereto irrevocably consent exclusively (a) to the jurisdiction and venue of the Courts of the First Judicial District of Harrison County, Mississippi, and of any federal court located in the Southern District of Mississippi, Southern Division, and agree that venue in each such Courts is proper in connection with any action or proceeding arising out of or relating to this Agreement and any exhibit or other document or instrument delivered pursuant to this Agreement; and (b) to the service of process by certified mail, return receipt requested.

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**Signature of Patient**

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**Date**