John M. Gowey, DDS, Inc.

HIPAA Release of information

AUTHORIZATION FORM

I,_________________________, hereby authorize Dr. John Gowey and its affiliates, its employees and agents (collectively _________________), to release to ____________________________ **[Insert full name of person/organization]** my personal health information maintained by Dr. John Gowey (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) except the following information about me:

____ **[DESCRIBE INFORMATION NOT TO BE DISCLOSED, IF ANY**] for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative's signature below and shall expire the earlier of ____________ **[INSERT DATE/EVENT UPON WHICH THIS AUTHORIZATION EXPIRES**] or the date my coverage ends with _______________.

I understand that I have a right to revoke this authorization by providing written notice to Dr. John Gowey. However, this authorization may not be revoked if Dr. John Gowey, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: ____

Signature of Member: _______________________________ **Date:** ______________________

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: _______________________________

Signature of Legal Representative: ___________________________ **Date**: _____________________

Name of Witness: _____________________ **Signature of Witness**: _____________________________

John M. Gowey, DDS

HIPAA PATIENT CONSENT FORM

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). A detailed description of the HIPPA policy is available for your review upon request.

May we leave a recorded message regarding your treatment or financial responsibilities on your home or cell phones? ☐ Yes ☐ No

This consent was signed by: ________________________________ **Date:** ______________________
(Patient, Parent, or Guardian)