AUTHORIZATION FOR THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

By signing below, I hereby authorize my health information, as more specifically described as follows: (the "Protected Health Information"), to be used or disclosed for the following purposes: _____ _____. *[If the use or disclosure is at the patient's request, insert "At the Patient's Request" instead of a specific purpose.]*

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are:

The person or class of persons to whom this office may use or disclose my Protected Health Information are:

_____

This Authorization shall expire on:

I understand that I have the right to revoke this Authorization, if the revocation is in writing, except if

- This office has taken action in reliance upon this Authorization; or
- This Authorization was given as a condition of obtaining insurance coverage and the insurance company has the right to contest a claim made under the insurance policy.

I understand that I may revoke this Authorization by delivering written notice to Emas Joseph MD

I understand that my Protected Health Information that is use or disclosed pursuant to the Authorization may be subject to redisclosure by the person(s) you have disclosed it to, and the privacy of my Protected Health Information will no longer be protected.

I acknowledge that I have read and understand this Authorization. I authorize the use of disclosure of my Protected Health Information in accordance with the terms of the Authorization.

_____ _____

Patient Print or Authorized Representative Print — Date Printed

_____ _____

Patient Signature or Authorized Representative Signature — Date Signed

Description of authorized Representative's authority to sign for the patient: _____

Insurance Authorization and Assignment: I hereby assign, to Oakland General Surgery, PLC payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Financial Agreement: I understand that I am financially responsible for all charges whether or not they are covered by my insurance as well as any co-payment and co-insurance. In the event of non-payment for any of these costs, I understand I will be legally responsible for all costs involved with the collection of this account including all court costs, attorney fees, and any expenses incurred, should this be required.

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

Medicare Certification: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Oakland General Surgery, for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.
I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Print _____ Date _____

Patient's Signature _____ Date _____

Parent/Guardian Print _____ Date _____

Parent/Guardian Signature _____ Date _____

TELEPHONE CONSUMER PROTECTION ACT OF 1991

By signing this document, I agree, in order for Oakland General Surgery, to service my account or to collect any amounts I may owe, Oakland General Surgery, and its third party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.

I/We have read this disclosure and authorize express consent that Oakland General Surgery, its affiliates and third party service providers may contact me/us as described above.

Patient's Print _____ Date _____

Patient's Signature _____ Date _____

Parent/Guardian Print _____ Date _____

Parent/Guardian Signature _____ Date _____