

Dr. Kenneth A. Godwin

301 Oxford Valley Road

Suite 903

Yardley, PA 19067

**Patient Release**

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the to the above-named physician for the services rendered. Initial\_\_\_\_\_\_\_\_\_\_

I understand that it is my responsibility to request a referral, if applicable, prior to my appointment. I agree to pay any deductible, co-payment or coinsurance applied by my insurance company, in addition to any uncovered service rendered by Dr. Godwin. I acknowledge that interest or a fee, at the providers current rate, may be charged on all balances owing to the provider that are past due. Initial\_\_\_\_\_\_\_\_\_\_

I agree to have my photograph taken and released when required for payment for medical claims; in addition, I authorize Dr. Godwin to use my photographs in medical settings when appropriate or required for treatment. I understand that my photographs may be submitted to my insurance provider to determine medical necessity for specific non-cosmetic and reconstructive surgery requests. Initial\_\_\_\_\_\_\_\_\_\_

I agree to have my photograph used for medical records, and if in the judgment of Dr. Godwin, medical research, education or science will benefit by their use, such photographs and information relating to my case may be published and used for any other purpose which he may deem proper in the interest of medical education or patient knowledge: provided, however that it is specifically understood that in any publication or website use I shall not be identified by name and any identifying characteristics will be diminished. If applicable, I agree to the use of TouchMD during my office visit with Dr. Godwin. Initial\_\_\_\_\_\_\_\_\_\_

I permit a copy of this release to be used in place of the original. Initial\_\_\_\_\_\_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent or Guardian, for minor child)