GERIG SURGICAL ASSOCIATES, P.C.

2006 South Main Street, Suite A, Goshen, IN 46526
Phone: 574.535.9100 Fax: 574.535.1020

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

______________________________ Name of Patient (Please Print)	______________________________ Date of Birth
______________________________ Street Address City State Zip	______________________________ Phone
______________________________ Maiden name or other name used for records	______________________________ Practice Use: Med Rec #
I hereby authorize: (Please Print)	To release to: (Please Print)
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

The following information from my records:

□ Complete Health Record (s)	□ History & Physical	□ Radiology Report
□ Operative Report	□ Laboratory Report	□ Pathology Report

□ Only Health Records from Dr(s)______________________________

□ Other (please specify)______________________________

I □ do □ do not (check applicable box) authorize this information to be faxed. If yes, fax number:______________________________

Covering the period from______________________________to______________________________

______(Initial) I understand that this authorization will include information relating to:

√ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV) infection
√ Psychiatric Care
√ Treatment for alcohol and/or drug abuse
√ Genetic Testing

If any, except as specifically stated here:______________________________

This information is to be disclosed for the purpose of______________________________

The date, extent or condition upon which this authorization expires is______________________not to exceed 60 days (except for research purposes, state "**NONE**" for expiration date). I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in sixty (60) days from the date below.

I understand and agree to pay a reasonable copying fee to cover the cost of transfer. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I understand that Provider's records may contain information created by an entity other than **GERIG SURGICAL ASSOCIATES, P.C.** and therefore is not responsible for the information contained in such incorporated information (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). I expressly request release of all records maintained by **GERIG SURGICAL ASSOCIATES, P.C.** concerning me, including incorporated records. I acknowledge that **GERIG SURGICAL ASSOCIATES, P.C.** has no and assumes no duty to me regarding the content of or omissions from such incorporated records.

I hereby release **GERIG SURGICAL ASSOCIATES, P.C.** and its personnel from all legal responsibility of liability that may arise from the act I have authorized above. **GERIG SURGICAL ASSOCIATES, P.C.** is not responsible for completeness, legibility, or omissions caused by the copying of any medical records from another institution.

______________________________ **Signature of patient or patient's representative**	______________________________ **Date**

Printed name of patient's representative______________________________Relationship to patient______________________________

Prohibition on redisclosure: This information, which has been disclosed to you from confidential records, is protected by federal law. Federal regulations prohibit you from making any further disclosure of this information except with the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information is held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provisions of this law shall be fined or imprisoned.