

**GERIG SURGICAL ASSOCIATES, P.C.**  
**GENERAL & VASCULAR SURGERY**

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**Acknowledgment/Consent to the Use and Disclosure of Health Information  
for Treatment, Payment, or Healthcare Operations**

I understand that as part of my healthcare, **Gerig Surgical Associates, P.C.** originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- *A basis for planning my care and treatment*
- *A means of communication among the many health professionals who contribute to my care*
- *A source of information for applying my diagnosis and surgical information to my bill*
- *A means by which a third-party payer can verify that services billed were actually provided*
- *And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals*

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the **Gerig Surgical Associates, P.C.** reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information in any public directory of **Gerig Surgical Associates, P.C.**

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that **Gerig Surgical Associates, P.C.** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that **Gerig Surgical Associates, P.C.** has already take action in reliance thereon.

**Gerig Surgical Associates, P.C.** records may contain information created by an entity other than **Gerig Surgical Associates, P.C.** **Gerig Surgical Associates, P.C.** is not responsible for the information contained therein (including the accuracy, completeness, relevance, legibility or lack thereof of such incorporated records). Patient expressly requests release of all records maintained by **Gerig Surgical Associates, P.C.** concerning patient, including incorporated records. Patient acknowledges that **Gerig Surgical Associates, P.C.** has no and assumes no duty to patient regarding the content of or omissions from such incorporated records.

No restrictions

I request the following restrictions to the use or disclosure of my health information: \_\_\_\_\_

\_\_\_\_\_

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**Signature of Patient or Legal Representative**

**Witness**

**Date Notice Effective: January 20, 2003**

**Gerig Surgical Associates, P.C.** was unable to obtain acknowledgment/consent because:

Emergency     Patient Non-Responsive     Patient Confused/Disoriented     Patient Sedated

Patient Refused, Reason \_\_\_\_\_

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This area for use by **Gerig Surgical Associates, P.C.** personnel only:

Restriction on use or disclosure:     Accepted     Denied

Signature: \_\_\_\_\_ Date: \_\_\_\_\_