General & Laparoscopic Surgical Associates, P.C.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: _____ SS#: _____

Persons/organization providing the information:
GENERAL & LAPAROSCOPIC SURGICAL ASSOCIATES, P.C.

Persons/organizations receiving the information:
Please list the name and relationship to you of family members and friends with whom we may discuss your protected health information:

Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____
Name: _____ Relationship to you: _____

Specific description of information:
Information contained in all billing and medical records.

Purpose of Disclosure:
Treatment, administrative operation of General & Laparoscopic Surgical Associates, P.C., or inquiries by the parties listed above.

PLEASE READ CAREFULLY

1. **I permit the release of all information indicated above including, if any, information concerning drug/alcohol treatment or use, psychiatric treatment or AIDS/HIV and other communicable diseases, test results and/or diagnosis and treatment.**
2. I understand that this authorization will expire when a time period of two(2) years has run without me receiving treatment from this practice.
3. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, except the extent the organization has taken action in reliance on the consent.

_____ _____
Signature Patient/Patient's Representative Date

_____
Printed Name of Patient/Representative

Basis of representative's authority to act for patient: _____

*******YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*******

ACKNOWLEDGEMENT

RECEIPT OF NOTICE OF PRIVATE PRACTICES

OF

GENERAL AND LAPAROSCOPIC SURGICAL ASSOCIATES
(CHARLES A. LANE, M.D., RICHARD H. WIKIERA, D.O., DANIEL S. JOHNSON, M.D., AND GARY STEINMANN,PA-C)

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE "NOTICE OF PRIVACY PRACTICES" FROM GENERAL AND LAPAROSCOPIC SURGICAL ASSOCIATES, P.C., AT 6810 STATE ROUTE 162, SUITE 100, MARYVILLE, ILLINOIS

WITNESSES:

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Date**

- **Documentation of Failure or Refusal to Obtain Signed Acknowledgement on**

  _____, 20____, _____, presented this
  (DATE) (NAME OF EMPLOYEE)
  Acknowledgement of Receipt Notice of Privacy Practices Forms to _____
  (PATIENT
  _____. The patient refused to provide a signature when explained.
  NAME)