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., DAVID CHUNG, M.D., KELSY WASMUTH, N.P.)

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)