GERIG SURGICAL ASSOCIATES
GENERAL • VASCULAR • BARIATRIC SURGERY

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

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 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 post a copy of the revised notice at the **Gerig Surgical Associates, P.C.** office and shall make a copy of the revised notice available to me upon request. 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 generally not required to agree to the restrictions requested. However, **Gerig Surgical Associates, P.C.** must agree to my request to restrict disclosures of my patient information to a health plan if the disclosure is for carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which I (or a person on my behalf other than the health plan) has paid **Gerig Surgical Associates, P.C.** in full. 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: _____

_____

_____ _____
Signature of Patient or Representative **Witness**

Date Notice Effective: January 1, 2020

Gerig Surgical Associates, P.C. was unable to obtain acknowledgement/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: _____