Gerald Lewis Inc.
3000 Murvihill Road, Valparaiso IN 46383
Phone: 219-286-3907 Fax: 219-286-3911

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

If this authorization is a medical records request for personal use only, check here._____
and this authorization may not be used for any other purpose.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

Patient's Name: _____
Date of Birth

Address: _____

Address: _____

Phone Number: _____

Email Address: _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed:

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to **disclose** the protected health information described above.

_____

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to **receive and use** the protected health information described above.

_____

_____

_____

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Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

_____

_____

3. ENDING THIS AUTHORIZATION

This authorization will end on the following date: _____
(If no date is specified, I understand this authorization will expire in 60 days from the date below).

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to Gerald Lewis Inc. However, I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. RE-DISCLOSURE OF INFORMATION

I understand that information used or disclosed pursuant to this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations.

7. PATIENT SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature:_____ Date:_____

Describe authority to sign on behalf of patient:_____

_____

Date revoked:_____ **Staff initials**:_____