Goshen Medical Practice
2240 Karisa Drive Suite 1
Goshen, IN 46526

Internal Medicine
Phone 574-534-6757
Fax 574-537-0357

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand if the person/ organization authorized to receive the information is not a health plan or health care provider, the release information may no longer be protected by federal privacy regulation. I agree a copy of this form may be treated as a signed original.

Patient name_____D.O.B._____

Address_____

City_____State_____Zip_____

Phone_____SS#_____Maiden_____

Persons/organization providing the information (previous MD, clinic)	Persons/organizations receiving the information
_____	Goshen Medical Practice - Dr. Bhagat
_____	2240 Karisa Dr, Suite 1 Goshen, IN 46526

Purpose of release Continuing care Attorney Insurance Other _____

DO NOT SEND THE ENTIRE MEDICAL RECORD!!

Please send ONLY the MOST RECENT progress note, lab results, EKG, Chest X-ray, Colonoscopy results, last annual wellness visit and vaccination history with all vaccines received by patient

The information release may include records regarding mental health, developmental disability, alcohol or drug abuse and/or infectious diseases (including HIV, AIDS, or AIDS-related conditions) unless specifically requested not to include these records.

The patient or the patient's representative must read and initial the following statements	Initial ↓
I understand the records will be available within 30 days unless I am otherwise notified	____
I understand I must be supervised if I am inspecting my records and there may be a fee	____
here may be a fee charged for the cost of furnishing a copy or summary of the health record	____
I understand this authorization will expire in sixty days. I understand I may revoke this Authorization at any time within the sixty days by notifying Goshen Medical Practice in writing. This revocation will not effect any actions already completed.	____

Patient signature_____ Date _____ -
OR-
Legal representative signature_____ Date _____

Printed name_____ Relationship _____