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
1)_____	_Goshen Medical Practice - Dr. Bhagat_____
2)_____	_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, ETC.

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 ____
There 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 _____