GAUTAM,JHA M.D.

1325 D W.WHITTAKER , SALEM IL 62881
PH. (618) 740-0300 FAX (618) 740-0301

Authorization to Use and/or Disclose Protected Information

I authorize] DR. JHA to use and/or disclose a copy of the specific medical information identified below for

(name of patient) _____

DOB: _____ SS# _____

to (name and address of recipient)

Gautam Jha M.D.
1325 W. Whittaker Suite D
Salem IL 62881
phone (618) 740-0300
fax (618) 740-0301

Date of Services from: _____ to _____

For the following purpose:

- ☐ Personal Use
- ☐ Judicial Proceedings
- ☐ Other (Must Specify) _____

Mail @: from:

_____

_____

_____

By marking the boxes below, I specifically authorize the use and/or disclosure for the following health information:

- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Consultations
- ☐ EKG
- ☐ Cath Lab Data
- ☐ Carotid/ABI
- ☐ Holter Monitors
- ☐ Echocardiograms
- ☐ Nuclear Stress tests/Treadmills
- ☐ Operative Report
- ☐ Patient Progress Notes
- ☐ Clinic Notes
- ☐ Green Sheets
- ☐ Patient Exam Form (Clinic)
- ☐ Laboratory/Pathology
- ☐ X-ray
- ☐ Entire Medical Record
- ☐ Other (Must Specify) _____

If there is more than 10 pages please mail records.

The following items must be initialed to be included in the use and/or disclosure of other health information:

_____ HIV/AIDS related information and/or records
_____ Mental Health information and/or records
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment or referral information

(Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe_____

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Physician's Office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (date)_____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. I also understand I may receive copies that were originated at another facility. If I have questions about disclosure of my health information, I can contact the Physician's Office.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Witness Date

_____ _____
Print Name of Patient or Patient's Representative Relationship to Patient

Provide a copy to the patient.