DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT AUTHORIZATION FOR PRACTICE TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Dr. Jeffrey D. Gaber & Associates, PA to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below. This authorization is needed for a purpose other than treatment, payment or health care operations. I have read this authorization and understand what information will be used or disclosed.

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing except to the extent that Dr. Jeffrey D. Gaber & Associates, PA has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Dr. Jeffrey D. Gaber & Associates, PA. I further understand there is a charge for copying and handling my request. I understand that all fees will be in compliance with applicable Maryland State guidelines.

This authorization permits Dr. Jeffrey D. Gaber & Associates, PA to use or disclose to _____ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, patient's name, age, race, condition or other medical or demographic information)

- Consultation Reports
- Discharge Summary
- Drug or Alcohol Treatment Records
- Emergency Room Records
- Medical Records/Notes
- Mental Health Records
- Operative Report
- Outpatient Records
- Outpatient Surgery
- Pathology Report
- X-Ray Report
- Other _____

I understand that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

This authorization expires on (upon) _____

Signature of Patient or Legal Guardian _____

Relationship to Patient _____

Patient's Name _____

Print Name of Patient or Legal Guardian _____

Date of Birth _____