DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE CIRCLE ANSWER

FROM / TO
Name/Practice:____
Address: ____
City, State, Zip: ____
Phone: ____
Fax: ____

FROM / TO
Dr. Jeffrey D. Gaber & Associates
341 N. Calvert Street, Suite 300
Baltimore, MD 21202
410-986-4400 Phone
410-986-4411 Fax

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 above. 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 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). **Mark with an "X".**

	Consultation Reports		Operative Report
	Discharge Summary		Outpatient records
	Drug or Alcohol Treatment Records		Outpatient Surgery
	Emergency Room Records		Pathology Report
	Medical Records/Notes		X-ray Report
	Patient's Initials required for records indicated below		Other:
	Mental Health Records		**Patient Initials**___________
	Drug and Alcohol Treatment Records		**Patient Initials**___________

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. I understand that there will be a charge for copying and handling any record requests and that I will pay all fees in compliance with the standard office policy regarding the payment of records. T this authorization will expire in one year unless I revoke this authorization earlier. I understand that in order to pick up any copies of records I may be requested to present license or other positive identification. Records may be released in paper, or electronic form. Any records transmitted electrically (e.g. via email) are subject to the Practice's email communication policy.

This authorization expires on (upon) ____. If no date is indicated, this Authorization automatically expires one year from its date.

____
Signature of Patient or Legal Guardian

____
Relationship to Patient

____
Patient's Name

____
Date

____
Print Name of Patient or Legal Guardian

____
Date of Birth