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Authorization for the Disclosure of Protected Health Information

To comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) 1996, this authorization form gives **FRANCIS M. GUMBEL, M.D., P.A.** permission to acquire, use or release specified health information for treatment, payment, and healthcare operations.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Date of Service(s): _____ **Social Security #:** _____--____--_____

Information may be disclosed to: (Entity Name, Address, Phone & Fax)	**FRANCIS M. GUMBEL, M.D.**
Information may be disclosed by: (Entity Name, Address, Phone & Fax)	
Purpose for Use/Disclosure:	**Continuation Of Care**

Medical Information to be disclosed and/or photocopied include(s):

_____ My complete medical records.
_____ Progress Notes
_____ Radiology Reports
_____ Photographs, videos, digital or other images, media
_____ Other information (Specify): _____
_____ History and Physical
_____ Lab Reports
_____ Pathology Reports

I hereby authorize you to disclose copies of any medical record, which may include **Drug, Alcohol, Physical Abuse, and Mental Health, HIV/AIDS,** other medical conditions and social information.

I know that I have the right to withdraw this authorization, in writing, at any time by sending such written notice to **FRANCIS M. GUMBEL, M.D., P.A. Medical Records Department or Compliance Office.** I also know that information used or disclosed before this authorization may be subject to re-disclosure by the person who received the information and may no longer be protected by federal or state law.

Treatment, payment enrollment or eligibility for benefits may not be conditioned on obtaining this authorization

My permission is only in force and effect until the following date or event;

☐ _____ (List expiration date or event), or

☐ End of research study (use or release is for research).

Authorization will expire one year from the date of signature if no date is provided.

Date: _____ **Time:** _____

Signature of Patient or Authorized Legal Representative **(Relationship to Authorized Patient)**

Signature of Witness **Date**