FRANCIS M. GUMBEL MD.,PA
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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 (HIPPA) 1996, this authorization form gives FRANCIS M. GUMBEL MD.,PA permission to acquire, use or release specified health information for treatment, payment, and health care operations.

PATIENT'S NAME_____ **DATE OF BIRTH**_____

Date of Service(s) _____Patient Social Security #_____

Information may be disclosed to: **(Entity Name, Address, Phone & Fax #)**	
Information may be disclosed by: **(Entity Name, Address, Phone & Fax#)**	
Purpose for Use/Disclosure:	

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

_____My complete medical records _____History and Physical
_____Progress Notes _____Lab Reports
_____Radiology Reports _____Pathology Reports
_____Photographs, videotapes, digital or other images, media.
_____Other Information (Specify)_____

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 MD.,PA 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 my 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 Person)

Signature of Witness Date