

**NASHAT Y. GABRAIL, M.D., INC.
dba GABRAIL CANCER CENTER**

4875 Higbee Av. NW, Canton, Ohio 44718
PH (330) 492-3345 FX (330) 492-0462

340 Oxford St., Dover, Ohio 44622
PH (330) 365-2135 FX (330) 364-9195

Individual Authorization

Patient Name: _____ **ID Number:** _____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

A representative of NASHAT Y. GABRAIL, M.D., INC., must answer these questions completely before providing this authorization form to you. DO NOT SIGN A BLANK FORM. You or your personal representative should read the descriptions below before signing this form.

Who will disclose the information? The person(s) or class of persons authorized to disclose the information are described below.

The physician(s) and other clinicians and staff members within Nashat Y. Gabrail, M.D., Inc.

Who will use and/or receive the information? The person(s) or class of persons authorized to use and/or receive the information are described below.

The physician(s) and other clinicians and staff members within Nashat Y. Gabrail, M.D., Inc.

What information will be used or disclosed? The description below should be in enough detail so that you (or any organization that must disclose information pursuant to this authorization) can understand what information may be used or disclosed.

Consultation/progress notes and/or clinical results/findings related to your total health and well-being.

What is the purpose of the use or disclosure? The purposes for which the information will be used or disclosed are described below.

To provide or facilitate treatment for your health and well-being.

When will this authorization expire? The date or event that will trigger the expiration of this authorization should be described below.

Authorization will terminate upon notification, in writing, from you or your personal representative.

SPECIFIC UNDERSTANDINGS

By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form. However, if you refuse to sign this form, then you or your personal representative will be asked to sign a medical release form each time records need to be released, except for treatment, payment, and normal business operations, disclosures to friends/family involved in your care, emergency or public need, or if information does not identify you.

You have a right to see and copy the information described on this authorization form in accordance with our record access policies. You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that we have already taken action based upon your authorization. To revoke this authorization, please write to Shelly Rentsch, Practice Administrator, 4875 Higbee Ave NW, Canton, OH 44718.

CONTACT INFORMATION

I authorize the following person(s) to have access or knowledge of my medical well-being

Print Name

Date

Print Name

Date

Print Name

Date

Print Name

Date

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

THE PATIENT OR HIS OR HER PERSONAL REPRESENTATIVE SHOULD BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.