AUTHORIZATION

Purpose: This form is used to confirm the direction of an individual that we use or disclose protected health information for a particular purpose.

SECTION A: The Individual (or the Individual's Personal Representative) confirming the authorization.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

☐ Yes, you may leave a message on my answering machine or cell phone confirming appointments or other information. Number(s) _____

Please list organizations we may disclose to: (primary care physician, specialists, hospitals, other facilities, etc.),

_____ _____

_____ _____

_____ _____

Please list individuals we may disclose to: (family members, neighbors, close friends, etc.)

_____ _____

_____ _____

_____ _____

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

I, _____, acknowledge that I have received **Christopher K. Quinsey, MD, PA** Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's medical record.
Send copy to the Privacy Officer.