

**AUTHORIZATION**

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

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**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.**