CHRISTOPHER K. QUINSEY, MD, PA

3272 W. Lake Mary Blvd. Suite 1810
Lake Mary, FL 32746-3589
Tel: 407-688-9898
Fax: 407-688-9229

Patient Name: _____
SS#: _____
DOB: _____

Before Signing, Cross Out Any Part(s) That Does/Do Not Apply.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Florida law requires that information contained in medical records be held in strict confidence and not be released without your written authorization. The authorizations you sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of this authorization upon your request.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ authorize _____
(Name of patient/legal representative) (Agency/individual in possession of record)
to release (**initial** by {a, b, c, d, e, f, g, h, i} any or all that apply):

_____ a. The general medical record created at the medical facility.
_____ b. The following information from the medical or case management record:
_____
_____ c. Records obtained from the following providers:
_____
_____ d. STD records
_____ e. TB records
_____ f. HIV/AIDS records
_____ g. Drug/alcohol treatment records
_____ h. Psychiatric/psychological information
_____ i. Adult and child abuse information

to: **Christopher K. Quinsey, MD, PA**
for the purpose of: _____

Date: _____ Signature of Patient/Legal Guardian: _____

Witness: _____ _____
(Legal Guardian's relationship to patient)

Dr. Phone: _____

Dr. Fax: _____

Dr. Address: _____

_____