Carolyn W. Quist, DO, P.A.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF

PROTECTED HEALTH INFORMATION

All Blanks Must Be Completed

_____ (name)

By signing this authorization, I authorize Carolyn W. Quist, DO, P.A. to use and/or disclose certain protected health information (PHI) about me to _____.
(Family Member or Friends)

This authorization permits Carolyn W. Quist, DO, P.A. to use/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of services, level of detail to be released, origin of information, etc.)_____

The information will be used or disclosed for the following purpose:_____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of information. This authorization will expire on_____.

The practice will__ will not__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Carolyn W. Quist, DO, P.A. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Office at: 1425 Eighth Avenue, Suite 101, Fort Worth, TX 76104.

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Print Name of Legal Guardian Relationship to Patient

_____ _____
Witness Signature Date