

**Authorization Form:**

I, \_\_\_\_\_, hereby authorize Kevin Mullins, MD, PC, Salvatore J. Palumbo, MD, PC, William E. McCormick, MD, PC, Borimir J Darakchiev, MD and Patrick J. Reid, MD to use the following protected health information, and/or disclose the following protected information to any physician and/or facility taking part in my medical care. As well as, Workers Compensation Carriers, No Fault Carriers, Insurance Carriers, Life Insurance Companies, Disability Carriers, Home Healthcare Agencies, Transport Services and Manufacturers of Braces, Prosthetics and/or Surgical Devices.

This protected health information is being used or disclosed for the following purposes:  
Medical/Surgical care.

This authorization shall be in force and effect until a yearly form has been updated at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager/Privacy Officer at 1175 Montauk Highway, Suite 6, West Islip, NY 11795. I understand that a revocation is not effective to the extent that this office has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Kevin Mullins, MD, PC, Salvatore J. Palumbo, MD, PC, William E. McCormick, MD Borimir J. Darakchiev, MD and Patrick J. Reid, MD will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.) and/ or
- Refuse to sign this authorization.

I have been informed that the Notice of Privacy Practices is available in the waiting room for me to read. I have also been informed that I may receive a copy if I so desire.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
Description of Personal Representatives Authority

Date \_\_\_\_\_