

**AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION
BY
JOSEPH R. LEITH, M.D., P.S.C.**

Information to be Used or Disclosed:

Persons to Whom Information May Be Disclosed:
Information Described Above May Be Disclosed to:

Name of person/organization

Relationship

Name of person/organization

Relationship

Name of person/organization

Relationship

You may revoke or terminate this authorization by submitting a written revocation to Joseph R. Leith, M.D., P.S.C. You should contact the Office Manager to terminate this authorization.

Name of Patient (please print)

Signature of Patient

Date

Signature of Patient Representative

Relationship