AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
BECKFORD MEDICAL CENTER, P.A.

Patient's Name:_____ **Date of Birth:** _____
Social Security #: _____ **MR #:** _____

I request and authorize Beckford Medical Center to disclose and release my healthcare information to :

Name: _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____

This request and authorization applies to :

- ☐ Healthcare information relating to the following treatment, condition, or dates: _____
  _____
- ☐ All healthcare information
- ☐ Other: _____

The purpose of this request is to: _____
_____

Initial all:

_____ I understand that medical records described above may include sensitive information relating to Workman's Comp, HIV/AIDS infection, psychologic diagnosis and treatment or drug and alcohol abuse information.

_____ This authorization shall become effective immediately and will expire on the following date, event, condition, or in six (6) months from date signed _____.

_____ I understand that I will receive a copy of this form after I sign it. I may see and request a copy of the information described on this form if I ask for it. I agree to pay any fees associated with copying of records. I also understand that any review of original medical records will be supervised.

_____ I understand I have the right to revoke this authorization, in writing addressed to the *Office Manager* at the address below. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ I understand that the authorized health information may be electronically communicated.

_____ _____
Signature of Patient *OR* Patient's legal representative Date

Printed name of patient's legal representative: _____
Relationship to patient: _____
Witness signature: _____ Date: _____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION ****
This form is used to obtain health care information voluntarily authorized by you.