HIPAA AUTHORIZATION FORM

Patient's Full Name	**Parent(s) Full Name**
Address	**Patient's Date of Birth**
City, State, Zip Code	**Patient's Telephone Number**

I have received the Notice of Privacy Practices for Beckman & Associates. Beckman & Associates may share my health information with:

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person, facility or healthcare provider is authorized to **use or disclose** information about me:

   _____

2. The following person (or class of persons) may **receive** disclosure of protected health information about me:

Name: _____

Name: _____

Name: _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying Beckman and Associates in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Guardian Personal Representative	**Date of Guardian's/Personal Representative's Signature**	**Relation to Patient**