J. CHRIS BECKMAN, M.D., PLLC
Phone # 615-893-8885
Fax # 615-893-8142

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize J. Chris Beckman, M.D., PLLC to use and/or disclose or to receive certain protected health information (PHI) about me to/from:

_____

Name and address of entity to receive or send this information

Phone # _____ Fax # _____

Other entities should send records to Dr. Beckman at J. Chris Beckman, M.D., PLLC, 1127 Dow Street Suite C, Murfreesboro, TN 37130. This authorization permits J. Chris Beckman, M.D., PLLC to use and/or disclose the following individually identifiable health information about me:

My medical record with the following item(s) checked below:

- ☐ Consult Notes: _____
- ☐ Labs: _____
- ☐ Imaging: _____
- ☐ Immunizations: _____
- ☐ Other: _____

My medical record with the **exception** of the item(s) checked below:

- ☐ Substance abuse, if any
- ☐ Psychological or psychiatric conditions, if any
- ☐ AIDS/HIV, if any
- ☐ Other: _____

The purpose of this request is "at the request of the individual," unless otherwise stated. The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire ninety (90) days from the date of signature below.

The Practice will not receive patient 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 J. Chris Beckman, M.D. 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 Officer at: 1127 Dow Street Suite C, Murfreesboro, TN 37130.

Signed by: _____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Patient's Name — Date

_____ _____

Print Name of Patient or Legal Guardian — Patient's Date of Birth

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION