BeamReaders®

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Once this form is completed, see the instructions for submitting this form to BeamReaders, located at the bottom of page 2.

Print Name of Patient: ____

Date of Birth: ____________________

I. My Authorization

I authorize BeamReaders, Inc. to disclose the following health information:

☐ - All of my health information in its possession

☐ - My health information covering the period from ___________ (date) to __________ (date)

☐ - Other: ____

BeamReaders, Inc. may disclose this health information to the following recipient:

Name/Practice ____

Address ____

City ____________________ State ____________________ Zip ____________________

Phone ___________________ Fax ____________________ Email ____________________

The purpose of this authorization is (check all that apply):

☐ - At my request

☐ - Other: ____

This authorization ends:

☐ - On (date)__________________

☐ - When the following event occurs: ____

Signature of Patient: ________________________________

Date: __________________

<u>If the patient is a minor or is unable to sign, please complete the following</u>:

☐ - Patient is a minor: _____________ years of age

☐ - Patient is unable to sign because: ____

Signature of Authorized Representative: ____

Date: _________________

Print Name of Authorized Representative: ____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: ______________________

<u>III. Additional Consent for Certain Conditions</u>

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ________________________________

Date: ___________________

<u>IV. Additional Consent for HIV/AIDS</u>

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ - I consent to have the above information released.

☐ - I do not consent to have the above information released.

Signature of Patient or Authorized Representative: ________________________________

Date: ___________________

**** **<u>Instructions for the practice submitting this form to BeamReaders</u>** ****

Upload both pages of this completed form to the Patient Files area of the case your practice creates for this patient on the BeamReaders website.