

**J. CHRIS BECKMAN, M.D., PLLC**

**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 \_\_\_\_\_ located at \_\_\_\_\_

Name of entity to receive or send this information

\_\_\_\_\_. Other entities should send records to Dr. Beckman at J. Chris Beckman, M.D., PLLC, P. O. Box 330097, Murfreesboro, TN 37133-0097. This authorization permits J. Chris Beckman, M.D., PLLC to use and/or disclose the following individually identifiable health information about me :

My entire 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 days from* the date of signature below.

The Practice will not receive payment 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: 630 South Church Street, Suite 300, 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*