BEALS INSTITUTE
ARTHRITIS, OSTEOPOROSIS and AUTOIMMUNE DISEASES

Diplomat, American Board of Internal Medicine and Rheumatology, Board Certified

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Patient Name (print): _____ Date of Birth ____/____/____

I authorize Beals Institute to discuss medical and/or billing information, and/or provide my personal health information to the following individuals;

Name	Relationship to Patient:	Phone:	☐ Medical ☐ Appointment ☐ Billing/Account
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My preferred contact is: ☐ **Phone OR** ☐ **FMH Patient Portal**

The office:
☐ ***MAY*** **leave messages about my care on a voicemail at this number:** _____
☐ ***MAY NOT*** **leave messages about my care on a voicemail or answering machine.**

Expirations or termination of authorization – This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to the Beals Institute.

Redisclosure – We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Beals Institute.

_____ _____
Patient Signature Date