Luna Beck, M.D.

Board Certified Internal Medicine

Protected Health Information Release Authorization

Today's Date: _____

Patient Full Name: _____ Date of Birth: _____

This will authorize Dr. Luna Beck MD to disclose my Protected health information to:

_____

as described for the following purpose:

_____

Date Service From: _____ To: _____

Check All That Apply:

Discharge Summary	_____	History Physical	_____
Progress Notes	_____	Consultation Notes	_____
Nurse Notes	_____	Laboratory Data	_____
E.R Records	_____	E.K.G.	_____
X-Rays, Imaging, etc.	_____	All Records	_____

Others: _____

Patient Initials: _____

This authorization shall expire upon this date: _____

** If I fail to specify an expiration date or event this information will expire one (1) year from the date it was signed.

I understand I have the right to revoke this authorization at any time. I understand that I must do so in writing and deliver the written revocation to

I understand that the revocation will not apply to information that has already been released to this authorization.

I understand that if I authorize disclose of protected health information, the recipient may further disclose this information, and may no longer be protected by federal rules.

Name: _____

Signature _____

Date Signed: _____ Relationship: _____

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