

Authorization to Disclose Protected Health Information to:

Beacon Medical Group, P.A.

Beacon Family Practice
26744 John J. Williams Hwy
Suite #3.
Millsboro, DE 19966
www.BeaconFamilyPractice.net
(302) 947-9767 Fax: (302) 947-9558

Beacon Pediatrics
18947 John J. Williams Hwy.
Suite #212
Rehoboth Beach, DE 19971
www.BeaconPediatrics.net
(302) 645-8212 Fax: (302) 645-2199

By signing, I hereby authorize:

Name: _____
(Name of physician/school/agency we are getting records FROM)

Address: _____ City: _____ State: _____ Zip: _____

To release the following information to Beacon Medical Group, P.A.:

Name of Patient: _____

Date Of Birth: _____ Gender M F SS# _____

Home Address: _____

Mothers Name: _____ Fathers Name _____
(In case of minor)

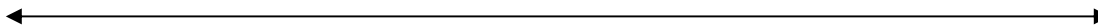
INFORMATION REQUESTED:

1. Dates of Treatment From _____ To _____

2. Check information that may be released.

___ Office Notes ___ Laboratory Reports ___ Hospital Reports ___ Consulting Reports
___ X-ray Reports ___ Ancillary Service's Reports ___ Therapy's
___ HIV/AIDS Results ___ Drug/Alcohol Results ___ Psychiatric/Psychology Notes
___ All Records
___ Other _____

Beacon Medical Group P.A. will not receive payment or other remuneration from a third party in exchange for using or disclosing the Protected Health Information.



I would like this authorization to expire on/or after the date/event listed: _____

I understand this authorization is only valid for **60 days** from the date of signature if I do not specify a date. I understand that I may revoke this consent at any time but not retroactive to the release of information made in good faith. I understand the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule. I understand that treatment, payment or other benefits cannot be conditioned on the execution of the Authorization.

Date

Signature of Patient/Legal Representative