MICHELE BECK-TORRES MD
Health Solutions for Women

Michele R. Beck, M.D

Obstetrics
Gynecology
Infertility and Tubal Microsurgery
Laser Surgery
Anti-Aging Medicine

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as directed as follows:

1. Person(s) authorized to use or disclose the information:
   _____
   _____
2. Person(s) authorized to receive the information:
   _____
   _____
3. Description of information that may be used or disclosed:
   _____
   _____
4. The information will be used or disclosed for the following purposes: (Note: if a patient initiates the request, the statement "at the request of the patient" is sufficient)
   _____
   _____
5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described previously may be re-disclosed and no longer protected by these regulations. _____(initial)
6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. _____(initial)
7. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. _____(initial)
8. This authorization expires one year from the date written below.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name (Please print)

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient