Stephen P. Beals, MD, PC

I have received and understand the
HIPAA Notice of Privacy Practices

Signature _____
Print Name _____
Patient Name (if minor) _____
Date _____

I authorize the following persons to pick up medical records or receive private medical information pertaining to my/my child's health care:

Name _____ relationship _____
Name _____ relationship _____
Name _____ relationship _____

Sign _____ Date _____