JUPITER MEDICAL CENTER

Release of Information Form

Phone- 561 263-7417 Fax 561 263-7416

2055 Military Trail, Suite 101
Jupiter, FL 33459

SECTION: A THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS:

Patient Name:	**Date of Birth:**
Phone:	**Last 4 Digits: SSN:**

This authorization will expire on (Date)_____

(If I fail to specify on expiration date, this authorization will expire in 90 days (6 months for series labs only)

(I understand that I have the right to revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.)

Requested Delivery: ____ Mail ____ Fax ____ CD _____ Picked up by _____

PURPOSE: ____ Legal ____Insurance ___ Personal ___ Continuation of Care ___ Clinical Research

Type of information to be disclosed: *(Please Check All That Apply)*

___Medical Abstract ____Labs ___Radiology Reports ___Emergency Record

___History and Physical ____Consultations ___Operative Report ___ECG/Echo Report

___Pathology/Cytology Reports ____Pathology Slides ___Tissue Blocks ___Discharge Summary

___ Other _____

Dates of Service Requested: _____

I hereby authorize release of information in my medical record which may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), records relating to behavioral or mental health services, and treatment for alcohol and/or drug abuse. ***INITIALS***_____

I authorize Jupiter Medical Center to release health information to:

_____

Name of person or facility to receive health information

_____

Street Address, City, State, Zip Code

Phone # _____ FAX # _____

Copies of records that are released for your own personal use are subject to a reasonable fee per page.

SECTION B: Signatures

Signature of Patient: _____ **Date:** _____

Signature of Patient Representative: _____ **Date:** _____

Relationship to Patient: _____ **Date:** _____

Witness: _____ **Date:** _____

SIGNATURE FOR PICKUP OF RECORDS: _____ **Date:** _____