JUPITER MEDICAL CENTER
2055 Military Trail, Suite 101
JUPITER, FLORIDA 33458

Authorization for Release of Patient-Identifiable Health Information

Acct #: _____
MR#: _____

For additional information please go to: www.jupitermed.com
For assistance with this form, please contact HIM: 561-263-7417

☐ Copy Photo ID ☐ Leave Telephone Messages

Patient Name:	Phone Number:
Date of Birth:	Last four digits of SS #:

The type of information to be used or disclosed is as follows (check the appropriate boxes):

☐ Medical Abstract (Commonly used for continuation of care)
☐ Labs
☐ Emergency Room Records
☐ History and Physical
☐ Radiology Reports
☐ Consultations
☐ Operative Reports
☐ ECG / Echo Reports
☐ Pathology/ Cytology Reports
☐ Discharge Summary
☐ Other _____

Dates of Treatment: _____

The type of information to be disclosed for the following purpose (check one box):
☐ Legal ☐ Insurance ☐ Self ☐ Continuation of Care

I authorize _____ to release health information to:
(name of person or facility which has information)

Name of person or facility to receive health information

Specify name/title of person to receive health information, if known

Street Address, City, State, Zip Code

Phone #_____ Fax #_____

Copies of the record may be (check one box):
☐ Mailed ☐ Picked up by _____
☐ Faxed (only to other healthcare providers in urgent situations)

INFORMATIONAL BROCHURE GIVEN:
☐ Yes Given ☐ Not Given ☐ Patient Declined **Initials:** _____

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), record relating to behavioral or mental health services, and treatment for alcohol and/or drug abuse. ***Initials*** _____

If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days (6 months for series labs only).

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

Signature of Patient:_____ Date: _____
Signature of Patient Representative:_____ Date: _____
Relationship to Patient:_____ Date: _____
Witness:_____ Date: _____

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

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