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

Authorization for Release of Patient Identifiable Health Information

Phone #: 561-263-7417
Fax #: 561-263-7416
For additional information please go to: www.jupitermed.com

Acct #: ______________________
MR#: ______________________

☐ 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
☐ Pathology Slides
☐ Discharge Summary
☐ Other ______________

Dates of Treatment: ______________________

PURPOSE (check one box):
☐ Legal ☐ Insurance ☐ Personnel ☐ Continuation of Care ☐ Clinical Research

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)

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 ____________

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: ____________

Form #JMC0260 Rev. 4/08, 1/09, 4/12, 2/14, 6/15, 10/16, 1/17