Jupiter Medical Center
Jupiter, FL 33458

Authorization of Release of Patient Identifiable Health Information

Patient Name _____ Med Rec Number: _____

Last 4 digits of SS#: _____

Date Of Birth: _____ **Telephone Number** _____

I authorize the use or disclosure of the above named individual's information as described below.

The following individual or organization is authorized to make the disclosure:

- ☐ Jupiter Medical Center, 1210 S Old Dixie Hwy, Jupiter, FL 33458
- ☐ Other,

Name: _____

Address: _____

_____

The type of information to be used or disclosed is as follows:

☐ Radiology Reports ☐ Radiology Films ☐ CD's

Date of Exam	Name of Exam	CD/Film

This information may be disclosed to and used by the following individual or organization:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of

- ☐ Continuation of Care
- ☐ Legal
- ☐ Personal Use
- ☐ Other (Be Specific): _____

I understand that I have a right to revoke this authorization at any time, I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released due to response to this authorization or the authorization was obtained as a condition of obtaining insurance coverage. Unless otherwise revoked this authorization will expire on the following date, event, or condition

_____

If I fail to specify an expiration date, event, or condition, this authorization will expire in six (6) months,

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Office of Jupiter Medical Center,

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).
I hereby authorize release of information in my medical record which may include information relating to behavioral or mental health services, and treatment for alcohol and/or drug abuse.

Initials: _____

Copies of the record may be (check appropriate):

☐ Mailed

Fed-Exed (Tracking Number _____)

Couriered to Physician's Office

☐ Picked up by _____

Faxed (only to other health care providers in urgent situations)

Signature of Patient: _____ Date: _____

Signature of Recipient _____ Date: _____

Relationship to Patient: _____

Signature of Patient Representative: _____ Date: _____

Date of Call: _____ Information Taken By: _____
(Employee)

Date of Pick Up: _____ Records Prepared By: _____
(Employee)

Records released by: _____ Date: _____
(Employee)