

Authorization for Release of Patient - Identifiable Health Information

Phone #: 561-745-7417
 Fax #: 561-745-7416

Acct #: _____
 MR# : _____

Copy Photo ID Leave Telephone Messages

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

CONTINUATION OF CARE:

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

Purpose: Continuation of Care

- | | |
|--|--|
| <input type="checkbox"/> Medical Abstract (Commonly used for continuation of care) | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> ECG / Echo Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Pathology/ Cytology Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Discharge Summary |

Dates of Treatment _____

PERSONAL:

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

PURPOSE:

- Legal Insurance Self

- | | |
|---|--|
| <input type="checkbox"/> Medical Abstract | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Labs | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Emergency Room Records | <input type="checkbox"/> ECG / Echo Reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Pathology /Cytology Reports |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Discharge Summary |
| | <input type="checkbox"/> Complete Record |

Dates of Treatment _____

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

Name: _____

Address: _____

Copies of the record may be (check appropriate box):

- Mailed
 Picked up by _____
 Faxed (only to other healthcare providers in urgent situations)
 CDROM

INFORMATIONAL BROCHURE GIVEN:

- Yes Given Not Given Patient Declined

Initials: _____

PATIENT SIGNATURE FOR PICKUP OF RECORDS: _____

DATE: _____



Authorization for Release of Patient- Identifiable Health Information

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 _____

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.

If these copies of records are for your own personal use there is a charge at the rate of \$1.00 per page pursuant to Florida Statute, Chapter 395.

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____