

**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*

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*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 (TrackingNumber \_\_\_\_\_ )
- 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)