JUPITER MEDICAL CENTER

Release of Information

Phone: 561 263-7417 Fax 561 263-7416

Jupiter Medical Center
1210 S Old Dixie Hwy, Jupiter, FL 33458

SECTION: A THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS:

Patient Name:	**Date of Birth:**
Phone:	**Last 4 Digits: SSN:**

I authorize Jupiter Medical Center to release health information to:

_____

Name of person or facility to receive health information

_____

Street Address, City, State, Zip Code

Phone # _____ FAX # _____

This authorization will expire on (Date)_____

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

(I understand that I have the right to revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.)

Requested Delivery Method: ____ Fax ____CD ____ MyChart Pick up by: _____

____ Mail To Above Address

PURPOSE: ____ Legal ____Insurance ___ Personal ___ Continuation of Care ___ Clinical Research
____ Other _____

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

Type of information to be disclosed: (*Please Check All That Apply)*

____Medical Abstract ____Labs ____Radiology Reports ____Emergency Dept. Record

____History and Physical ____Consultations ____Operative Report ____ECG/Echo Report

____Pathology/Cytology Reports ____Pathology Slides** ____Tissue Blocks** ____Discharge Summary

****Pathology Slides/Tissue Blocks are only provided directly to facilities and returned for patient care only**

____Cardiac Cath Lab Images ____Urgent Care Center Records

____Other: _____

DATE OF SERVICE for requested records: _____

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 _____***

SECTION B: SIGNATURES

Signature of Patient: _____ Date: _____

Signature of Patient Representative: _____ Date: _____

Representative Name: _____

Relationship to Patient: _____ Date: _____

SIGNATURE AT PICKUP OF RECORDS: _____ Date: _____

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DIRECTIONS for completing the Release of Information Authorization form

Section A:

- Provide the patient's name, date of birth, phone number and last 4 digits of SSN
- Delivery Method: Fax number must be given to send information to your healthcare provider.
- Provide the reason for the requested release of information in the "PURPOSE" section.
- Indicate what information you are requesting. Most common is "Medical Abstract", which provides the discharge summary, history and physical, ER Report consults and operative reports from the physicians, along with test results, such as labs, radiology, and pathology. Otherwise, indicate the specific information requested.
- Please indicate the dates of service (treatment) for which you are requesting records.
- Initial that you acknowledge and consent that the records requested for release may contain the special types of information listed.
- Provide the name of the person/facility you want your information released to. This may be someone other than the patient, such as: patient's spouse, parent, power of attorney, healthcare provider, etc. If the person receiving the records is the patient, just write: "SELF"
- If the person receiving the records is the patient, provide the address of the patient. If the person/facility is different than the patient, provide the address and phone number of the person/facility. Provide fax number for healthcare providers.
- There may be a copy fee for the information you requested.

Section B:

- The form must be signed and dated by the patient or the patient's LEGAL representative (Some examples of Legal representative: power of attorney, legal guardian, healthcare surrogate). A spouse is *not* a LEGAL representative unless they have LEGAL power of attorney or healthcare surrogacy paperwork. A COPY OF PROOF OF LEGAL REPRESENTATION PAPERWORK MUST ACCOMPANY THIS REQUEST.
- A photo ID of the person picking up the records will be required at time of pick up