Jupiter Medical Group

Medical Records Consent

Today's Date:_____

Patient Name: _____ **Patient Date Of Birth:**_____
Address: _____
City, State, Zip: _____
Patient Phone Number: _____

Please send my medical information to:
Jupiter Medical Group
1447 Medical Park Blvd, Suite 405
Wellington, FL 33414
Office: 561-792-7484; Facsimile: 561-792-7488

Facility to Obtain/Send Records:
_____
_____
_____
Phone:_____ **Fax**: _____

Reason for Request/Release: _____

❑ Request for Records ❑ Release of Records

Above- listed patient authorizes the following healthcare facility to the release/request record disclosure for continuation of care:

☐ Entire Record	☐ Lab Reports	☐ Diagnostic Reports
☐ Radiology Reports	☐ Discharge Summary	☐ History and Physical reports
☐ Pathology Reports	☐ Medication List	☐ Consultation Reports
☐ Psychiatry/Mental Health	☐ Progress Notes	☐ Other:_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand I may 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 in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire 180 days following the date of signature.** 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 assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

Records release to another physician is free of charge, however, if we release records to you personally or to another entity other than a medical facility then there will be a $15.00 fee charge.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Patient Signature Date