



**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  
210 Jupiter Lakes Blvd., Bldg. 5000, Suite 103  
Jupiter, FL 33458  
Office: 561-747-7377; Facsimile: 561-743-7616

**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:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Entire Record            | <input type="checkbox"/> Lab Reports       | <input type="checkbox"/> Diagnostic Reports           |
| <input type="checkbox"/> Radiology Reports        | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical reports |
| <input type="checkbox"/> Pathology Reports        | <input type="checkbox"/> Medication List   | <input type="checkbox"/> Consultation Reports         |
| <input type="checkbox"/> Psychiatry/Mental Health | <input type="checkbox"/> Progress Notes    | <input type="checkbox"/> 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, there will be a fee of \$1.00 per page for the first 25 pages and \$0.25 for each page over 25.**

**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