Pick up: _____ Medical Record # _____
Mail out: _____

JACKSON HEALTH SYSTEM
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL RECORDS

PATIENT NAME: _____

DATE OF BIRTH: _____ TREATMENT DATE(S): _____

PHONE NUMBER: _____

1. Please note that:

- The Public Health Trust is required by federal and state law to protect your health information.
- The person or organization that receives your health information may not be required by federal law to protect it and may share your information with others without your permission. The person or organization that receives your health information may be required under state law to use your information only for the purpose you stated and may not share your information without your written permission. In particular, the receiving person or organization may not be allowed to share any information about HIV test results, substance abuse, psychiatric/psychotherapy or sexual assault without your permission.
- The Trust cannot condition your treatment, payment, enrollment or eligibility for benefits on whether or not you sign this Authorization.
- You do not have to sign this Authorization form, but if you do not, we will not provide your health information to the person or organization you have requested.
- You may change your mind and revoke (take back) this Authorization at any time. If the Trust has not yet released your health information and you change your mind, it will not release your information. However, if the Trust relied on this Authorization before you changed your mind and released your health information, the person we gave it to may still disclose the health information they have already received. The Trust relied on this Authorization if the Trust had forwarded your health information to the person or organization that you requested.
- To revoke this Authorization you must write to the Privacy Officer at Jackson Health System, Jackson Medical Towers, 1500 N.W. 12th Avenue, Suite 102, Miami, Florida 33136.
- Your permission to release your health information will automatically expire twelve (12) months from the date that you signed this form, unless you revoke your permission earlier or you choose a different date: _____ (list a specific date or event - e.g., at the end of the research study, six months from now, etc.).

2. I _____(patient/authorized representative) give permission to the Public Health Trust of Miami-Dade County/Jackson Health System to release health information that identifies _____ patient (Select one of the following):

a. _____ Complete Medical Record (covering the period(s) of: _____)
(Please note that by selecting this option this will not provide you with your billing records. In order to request your billing records, please select option 2.c. HIV test results may be released with the Complete Medical Record if you have signed a prior written authorization to release HIV test results.): **OR**

b. _____ Complete Psychiatric/Psychotherapy Record (covering the period(s) of: _____)
(You cannot combine this authorization to release psychiatric/psychotherapy records with any other authorization for release of records. Please complete a second authorization form in order to release any other health records.): **OR**

c. _____ Billing Records (covering the period(s) of: _____)

d. _____ Release shall be limited to the following specific types of information (covering the period(s) of: _____):

_____ Discharge Summary
_____ Emergency Department Record
_____ Progress Notes
_____ Operative Reports
_____ Pathology Reports
_____ EKG Reports
_____ History and Physical Examination
_____ Consultation Reports
_____ Laboratory Tests
_____ X-Rays or other images
_____ Surgical / Autopsy slides
_____ Description of medical condition by name, diagnosis, treatment, etc.
_____ Photographs, videotapes, audiotapes, other recordings
_____ Health Insurance Information
_____ Outpatient Records
_____ Clinical Lab Reports
_____ Other (specify): _____ ; **OR**

e. _____ Other: _____.

3. **I, _____give specific consent to release my medical records that relate to the following areas (please sign your name next to all that apply):**
Patient/Authorized Representative

_____ HIV Test Results _____ Substance Abuse _____ Sexual Assault

4. **The purpose for which my health information is being released is: (please initial)**

_____ Continuing Care _____ Legal _____ Insurance _____Personal _____ Other: _____

5. **I give permission for the health information listed above to be released to the following individual(s), organization(s) or entity(ies):**

Name: _____ Phone:_____

Address: _____ Fax: _____; **OR**

_____

_____

Name: _____ Phone:_____

Address: _____ Fax: _____; **OR**

_____

_____

Name: _____ Phone:_____

Address: _____ Fax: _____; **OR**

_____

_____

Name: _____ Phone:_____

Address: _____ Fax: _____; **OR**

_____

_____

Name: _____ Phone:_____

Address: _____ Fax: _____; **OR**

_____

_____ _____
Patient Signature Date

_____
Parent/Authorized Representative – sign and print

_____

_____
Indicate Relationship to Patient

PATIENT IMPRINT

<<Produce in duplicate with instruction to give one copy to patient or authorized representative.>>