Jupiter Family Medicine, P.C.

Authorization for
RELEASE OF MEDICAL INFORMATION

Patient Name _____ Date of Birth ___/___/_____
Address _____
City _____ State _____ Zip Code_____
Phone (_____)_____ Last 4 digits of Social Security Number (optional) _____

I AUTHORIZE MY RECORDS TO BE SENT FROM:
Jupiter Family Medicine PC – 6250 Jupiter Ave NE Suite A – Belmont, MI - 49306
I AUTHORIZE MY RECORDS TO BE RELEASED TO:
Name/Organization: _____
Address _____
City _____ State _____ Zip Code_____
Phone (_____)_____ Fax (_____)_____

PURPOSE OF DISCLOSURE:
☐ Transferring care to a new office ☐ Continuation of care with another organization/provider
☐ Insurance ☐ Attorney/Legal ☐ Other _____
_____ (initial) Please note that Jupiter Family Medicine will provide 30 days of emergent care, including non-controlled prescription refills, for 30 days from the date of this release for patients transferring care to a new office.

INFORMATION REQUESTED:
☐ Complete chart ☐ Office visit notes ☐ Radiology/Lab results ☐ Immunization record
☐ Specialist correspondence/Hospitalization ☐ Other _____
From this/these date(s) of service: _____

If you DO NOT WANT to release any of your specially protected information in the categories below, check the box(es) for that category:
☐ Information about communicable diseases and infections, as defined by statue and Michigan Department of Public Health Rules, which include venereal disease (VD), tuberculosis (TB), hepatitis B, human immunodeficiency virus (HIV), HIV test, acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC) and _____
_____ (specify other if known)
☐ Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal Regulations, Part 2.
☐ Mental health treatment records, psychological services and social services information, including communications made by me (the patient) to a social worker or psychologist.
☐ The release of my DNA test result regarding a diagnosis of _____
(such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

I understand that patient discharge instructions and records from other health care providers may be released with this routine request. I also acknowledge that Jupiter Family Medicine, PC, assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a provider not employed by Jupiter Family Medicine, PC.
There is a potential that information disclosed in this authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974, as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.
This authorization may be revoked in writing at any time as outlined in the Jupiter Family Medicine, PC, Notice of Privacy Practices. Jupiter Family Medicine, PC, does not require this authorization as a condition for giving treatment, payment enrollment or eligibility of benefits.
This authorization is valid for one (1) year from the date of my signature, unless I specify another date: _____

Patient or legal representative: _____ Date _____
Basis of legal authority to act for patient:_____
Witness _____ Date _____
Second Witness _____ Date _____
(required if patient is unable to sign or gives verbal permission)