Jupiter Family Medicine, P.C.

Authorization for Sharing Information

THINGS YOU SHOULD KNOW (PRIVACY NOTICES):

1. You should know that signing this form gives Jupiter Family Medicine (JFM) your consent to use and disclose your protected health information (PHI) to carry out treatment, payment, and health care operations (TPO). JFM's Notice of Privacy Practices describes such uses and disclosures more completely and you have the right to review this notice at any time. JFM reservices the right to revise its Notice of Privacy Practices at any time.
2. You should know that **if using a policyholder/parent's health insurance plan** for services, JFM and the insurance company may share your information to the policyholder/parent for services performed. **In addition, they would receive an explanation of benefits, and may gain access to medical and billing information about your visit.**
3. Understand that this consent **will be in effect** until you revoke it in writing **or** for the **period specifically listed** here: _____. Please note that completing a new Authorization to Share form automatically replaces the previous version on file.
4. If you give permission to share your health information with another person, that person could **re-disclose** your health information and your information is no longer protected by Federal privacy regulations. Your health care will not be affected if you do not sign this form.

Patient's Information:			
Patient's Name:		Maiden or other name:	Date of birth:
Address:			
City:	State:	Zip code:	
Preferred phone number:	Alternate phone number:		

I CONSENT to share my health information with the following individual(s) (WHO we can share with):	
Name:	Date of birth (if available):
Address:	
Phone:	Relationship to patient:

Name:	Date of birth (if available):
Address:	
Phone:	Relationship to patient:

This is where YOU decide if you authorize JFM to share your information as listed above (initial one):

☐ **I AGREE** to share/release all relevant information, **INCLUDING release of all of the following.**
Special consent information: HIV (Human Immunodeficiency Vicus) related illness, testing OR sexually transmitted diseases; AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex); information about Alcohol and Drug Abuse diagnosis and/or treatment; Information about Mental Health Services and Social Services. In addition, other private information such as pregnancy or contraceptive management information can be shared.
EXCLUSION – Records excluded from disclosure are those that meet the requirements for CFR 42 Part 2 and require a separate consent for release.

☐ **I AGREE** to share/release all relevant information, **EXCLUDING special consent areas above.**

☐ **I AGREE** to share/release **ONLY** this specific information: _____

☐ **I DECLINE** to share/release my health information.

_____ OR _____

Signature of Patient Date Signature of parent/legal guardian Date

Revised 1/2/2024