

JOVE MEDICAL
3111 45th Street, Suite 3
West Palm Beach, FL 33407

Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize **Jove Medical** to use and/or disclose certain protected health information (PHI) about me to _____.

Name of Person or Entity, Provide Phone and/or Fax Number

This authorization permits **Jove Medical** to use and/or disclose the following individually identifiable health information about me:

The information will be used or disclosed for the following purpose:

- At the request of the individual
- At the request of another health care provider
- For coordination of services or referral purposes
- Other _____

This authorization will expire on _____ (date).

I understand I do not have to sign this authorization form in order to receive treatment from **Jove Medical** and have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Jove Medical
3111 45th Street, Suite 3
West Palm Beach, FL 33407
Ph: 561-420-8820

Signed by: _____

Signature of Patient or Legal Guardian

Relationship to Patient

Print Patient's Name

Date

Print Name of Legal Guardian, if applicable

