

Jove Medical, Inc.
3111 45th Street, Suite 3
West Palm Beach, FL 33407
Phone: (561) 803-7600

Patient Authorization for Use and Disclosure of Protected Health Information

By signing below, I authorize _____
Name of Provider or Facility; Provide Fax and/or Phone No.

To use and/or disclose certain protected health information (PHI) about me to Jove Medical, to include the following:

- ___ Lab results (i.e. pap tests, routine, specific tests): _____
- ___ Diagnostic tests (i.e. X-rays, Mammogram results): _____
- ___ History and Physical
- ___ Discharge Summary
- ___ Medication List
- ___ Other _____

For the following date(s): ___ Most Recent OR _____.
Enter date (Month and/or Year)

This authorization will expire on _____.
Enter Date

Signature of Patient or Legal Guardian

Date

Print Patient's Name or Name of Guardian

Relationship to Patient