

JOI UNIVERSITY DIVISION  
5737 Barnhill Drive Suite 102  
Jacksonville FL 32207  
904-739-3319 Phone  
904-448-1416 – Fax



**AUTHORIZATION FOR DISCLOSURE OF HEALTH CARE INFORMATION**

**PATIENT INFORMATION**

PATIENT'S NAME: \_\_\_\_\_  
*First Name Middle Name Last Name*

Other Name \_\_\_\_\_  
SSN: \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

JOI ACCOUNT NUMBER(S) \_\_\_\_\_  
*Account Number 1 Account Number 2*

**Authorized Individual Information**

I hereby give authorization to Jacksonville Orthopaedic Institute to release healthcare information regarding myself

\_\_\_\_\_ to the party listed below  
*Patient's Name*

NAME: \_\_\_\_\_  
*Authorized Individual*

ADDRESS \_\_\_\_\_  
\_\_\_\_\_  
*City State Zip*

**Authorized Information – this authorization applies to the following selected range(s) of information**

- I authorize the release of all information regarding the status of my healthcare, including but not limited to treatment plan & Results of radiology tests to the person listed above
- I authorize the release of all Healthcare information to the person listed above, related to the following treatment, condition Dates and procedures
- I authorize the release of my billing and/or financial records to the person listed above

**Protected Healthcare Information (PHI)**

- yes no I authorize the release of my STD results ,HIV/AIDS testing, whether negative or positive to the person listed above
- yes no I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person listed above.

**Telephone Contact & Message Authorization**

Jacksonville Orthopaedic will attempt to contact you via telephone regarding test results, at the phone number you have provided. Please indicate below if you permit JOI to leave voicemail messages containing this information:

- I authorize Jacksonville Orthopaedic Institute to contact me by telephone
- DO NOT** leave a message on my answering machine.  Leave a message on my answering machine.

I understand that this authorization shall be valid for **ninety (90) days** unless I revoke this authorization through written notice to Jacksonville Orthopaedic Institute P.A. at the address listed above.

\_\_\_\_\_  
*Patient or Patient's Representative Signature Relationship to Patient*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Authorization Date Authorization Expiration Date*