JACKSONS' POINT OF LIGHT
FAMILY MEDICINE, INC.
"Live Life Well"

1810 Stadium Drive
P.O. Box 1045
Phenix City, AL 36868-1045
www.jplfamilymed.com
(334) 291-5255
(877)395-0710 Fax

info@jplfamilymed.com
Kimberly A. Jackson, M.D.
President

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth:_____

Previous Name: _____ Social Security #:_____

I request and authorize KIM FUNCHES-JACKSON, M.D.to release healthcare information of the patient named above to (Please provide phone and fax number):

_____ _____
PHONE *FAX*

_____
CLINIC OR DOCTOR'S NAME

_____ _____
(STREET) *(SUITE)*

_____ _____ _____
(CITY) *(STATE)* *(ZIP)*

This request and authorization applies to:

☐Healthcare information relating to the lowing treatment, conditions, or dates:	
☐All healthcare information	
☐Other specific information request	

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign the consent, JPL Family Medicine, Inc. can exercise the option to decline to provide medical service to me. This facility, its employees and physicians are released from legal responsibility or liability for the above medical records to the extent indicated and authorized herein.

Patient/ Legal Guardian
Signature: _____ Date Signed:_____

By signing this form, I am consenting to Dr. Jackson's use and disclosure of my personal health

information to treatment providing organizations to carry out medical treatment.

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Date mailed/faxed: _____ **For office use only:** Staff initials_____