



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

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Kimberly A. Jackson, M.D.
President

CONSENT TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize; _____
(NAME)

(STREET)

(CITY) (STATE) (ZIP)

to release healthcare information of the patient named above to:
KIM JACKSON, M.D.
1810 STADIUM DRIVE, SUITE 210
PHENIX CITY, AL 36867
FAX (877) 395 0710

This request and authorization applies to:

- Healthcare information relating to the following treatment, conditions, or dates:
- All healthcare information
- Other: _____

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 other 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 _____