Jones
Medical Supply

Authorization for Release of Medical Records

Patient Name_____ DOB _____

Address _____City_____ St _____ Zip _____

HOME Telephone _____ NOK _____ CELL _____

_____
Email Address (Optional)

I authorize Jones Medical Supply, LLC **(herein "Jones")** to receive copies of all of my medical records, including, but not limited to progress notes, operative notes, laboratory results, sleep studies, prescriptions, and diagnostic tests. Disclosure of personal health information will be handled as outlined in the Jones Current Notice of Privacy Practices. A photographic copy of this authorization shall be as valid as the original. This authorization is valid until cancelled in writing by either party. This release shall be valid while services are being rendered from Jones, unless cancelled in writing.

I further elect to choose JONES MEDICAL SUPPLY, LLC as my supplier effective the date of this notice and authorize and direct any previous supplier, to release any and all documents, including but not limited to diagnostic tests results, sleep studies, and sales orders, relating to my prior service.

X_____ _____
Patient's Signature Date

_____ _____
If Patient is unable to sign, Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Representative's relationship to the patient:

_____

Please fax medical records to 334-566-1003