



**AUTHORIZATION FOR RELEASE OF INFORMATION**

**Section A: Must be completed for all authorizations**

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Social Security: \_\_\_\_\_ Phone: \_\_\_\_\_

**Persons/organizations providing the information:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
**Fax #:** \_\_\_\_\_

**Organizations receiving the information:**

**Bone and Joint Institute of Tennessee**  
**3000 Edward Curd Lane**  
**Franklin, TN 37067**  
**Phone: 615-791-2630 Fax: 615-791-2639**

What is the purpose of the use or disclosure? **At the request of the Individual**

**Section B: Must be completed only if the healthcare provider has requested the authorization**

- Will the healthcare provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? \_\_\_\_ Yes X No
- Information to be disclosed: The information to be disclosed includes only those items checked below, with respect to services provided on or around NEXT APPOINTMENT DATE.

<input checked="" type="checkbox"/> Entire Medical Record	<input checked="" type="checkbox"/> Lab/Pathology results	<input checked="" type="checkbox"/> HIV/AIDS test results
<input checked="" type="checkbox"/> Discharge summary	<input checked="" type="checkbox"/> Diagnostic reports	<input checked="" type="checkbox"/> Alcohol/Drug treatment
<input checked="" type="checkbox"/> History and physical exam	<input checked="" type="checkbox"/> ER visit	<input checked="" type="checkbox"/> Other (specify): _____
<input checked="" type="checkbox"/> Radiology images		

**Section C: Must be completed for all authorizations**

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the physician declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

I understand that I may revoke this authorization at any time by sending a written notice to the Medical Group. However, the revocation will not have any effect on any uses or disclosures the Medical Group may have made before the revocation was received. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed. I understand that I may refuse to sign this Authorization and that the Medical Group will not condition treatment on whether I sign this Authorization.

I certify that I am:

The patient and the identification that I provided is true and correct.

The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: \_\_\_\_\_

Signature: \_\_\_\_\_

\_\_\_\_\_ Date

Print Name: \_\_\_\_\_

**BJIT USE ONLY:**

Date Received:	
How was identity verified:	Copy Made? <input type="checkbox"/> Yes <input type="checkbox"/> No
How was authority verified:	Copy Made? <input type="checkbox"/> Yes <input type="checkbox"/> No
Completed by: _____	Date: _____