BJI
BONE AND JOINT
INSTITUTE

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: _____

Social Security: _____ Phone: _____

Persons/organizations providing the information:
Vanderbilt University Medical Records
Fax: (615) 343-0126

Organizations receiving the information:
Bone and Joint Institute of Tennessee
4323 Carothers Parkway Suite 201
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

1. 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
2. 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.

☒Entire Medical Record	☒Lab/Pathology results	☒HIV/AIDS test results
☒Discharge summary	☒Diagnostic reports	☒Alcohol/Drug treatment
☒History and physical exam	☒ER visit	☒Other (specify): _____
☒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? ☐Yes ☐No
How was authority verified:	Copy Made? ☐Yes ☐No
Completed by: Date:	