

**Tennessee Spine and Joint Center, P.C.**  
**2011 Murphy Avenue, Suite 309**  
**Nashville, TN 37203**  
**Phone: (615) 298-3205**  
**Fax: (615) 298-3283**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
 \_\_\_\_\_ Patient's Phone: \_\_\_\_\_

**1. The information is to be disclosed to the following persons or organizations:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_

**2. Purpose. The purpose of the use or disclosure is:**

- At the request of the patient.
- Other: \_\_\_\_\_

The following medical records:

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Progress Notes/Impairment Rating
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> Consultation Reports
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Summary of Treatment
<input type="checkbox"/> X-Ray Reports or Films *	<input type="checkbox"/> Statement of Account
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> HIV/aids test results and treatment
<input type="checkbox"/> Operative Record	<input type="checkbox"/> Alcohol and Drug Testing Records

\* When a patient requests a copy of their x-rays they will receive a copy. The originals have to remain at the clinic. They may also incur a fee for the copies.

**3. Revocation.** I understand that I may revoke this authorization at any time by sending a written notice to Tennessee Spine & Arthroplasty Ctr., P.C. However, the revocation will not have any effect on any uses or disclosures Tennessee Spine & Arthroplasty Center., P.C. may have made before the revocation was received.

**4. Expiration.** I understand that unless I revoke the authorization earlier, this authorization will automatically expire twelve (12) months after the date this authorization is signed.

**5. Redisclosure.** I understand that the information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

**Refusal to Sign.** I understand that I may refuse to sign this Authorization and that Tennessee Spine & Arthroplasty Ctr., P.C. will not condition treatment on whether I sign this Authorization.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_\_

Witness: \_\_\_\_\_

Signature: Patient/Guardian