Authorization to Release Health Information

Patient Name ______________________________ Date of Birth ______________

Address ____

____

Patient Phone # ____________________________ SSN ______________

This information is requested from ______________________________

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

Name ______________________________

Address ______________________________

Requested from ❑ Patient ❑ Other

❑ The following medical records:

❑ Entire Medical Record	❑ Progress Notes/Impairment Rating
❑ History and Physical Exam	❑ Consultation Reports
❑ Lab Results	❑ Summary of Treatment
❑ X-Ray Reports*	❑ Statement of Account
❑ Discharge Summary	❑ HIV/AIDS Test Results & Treatment
❑ Operative Record	❑ Alcohol & Drug Testing Records

When a patient requests a copy of their x-rays they will be receiving a copy. The originals have to remain at the MTBJ Clinic. They may also incur a fee for the copies.

Revocation I understand that I may revoke this authorization at any time by sending a written notice to MTBJ Clinic. However, the revocation will not have any effect on any uses or disclosures MTBJ Clinic may have made before the revocation was received.

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.

Expiration I understand that 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 MTBJ Clinic will not refuse treatment as as a result of not signing the Authorization.

Signed this ________ day of ____________________ 20 ________

Witness ______________________ Patient/Guardian Signature ______________________

931.381.BONE (2663) | 800.552.BONE (2663) | FAX 931.380.0513
1050 N. James Campbell Blvd., Suite 200 | Columbia, Tennessee 38401

FORM 030508