



WEST TENNESSEE

BONE & JOINT

Sports Medicine • Orthopedic Excellence

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient: _____

Date of Birth: _____

Social Security No. _____

I hereby authorize WEST TENNESSEE BONE & JOINT CLINIC, PC to use or disclose my individual health information to: (Name and Address)

For the following purpose: _____

I understand that this authorization allows WEST TENNESSEE BONE & JOINT CLINIC, PC to release copies of any and all documents in my medical record including information related to HIV information, drug and alcohol use and Psychiatric Conditions if applicable. this authorization is effective immediately and shall remain in effect for 60 days from the date below. **You may revoke this Authorization at any time, in writing,** except to the extent that we may have already relied upon it in making a use or disclosure.

Patient's Signature or Legal Representative

Date

Relationship to Patient