WEST TENNESSEE BONE&JOINT
"Keeping You Active"

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*The undersigned authorizes **West Tennessee Bone & Joint** to release my health information as noted below.*
24 Physicians Drive ▪ Jackson, TN 38305
Ph. 731-661-9825 ▪ 731-668-6757

Please Print

Patient Full Name: _____ **Chart #** _____ **Notes:** _____

Patient Address: _____ **Date of Birth:** _____ **Provider Initials:** _____

City: _____ **State:** _____ **Zip:** _____ **Phone #:** _____ **SS#** (last 4 digits)_____

Release Information To

Request Purpose: ☐ Form ☐ Records - ☐ Physician ☐ Paper Copy Mailed ☐ CD Mailed ☐ E-Mailed ☐ Radiology Disc

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Fax #:** _____

Email address for record delivery: _____

Your record/form(s) will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email.

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

___ Please release an **Abstract** of my records (Office notes, labs, procedures & testing) ☐ Last 2 Years ☐ 5 Years

___ **Date Range**: _____

□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Injections □ Physical Therapy
□ Other: _____

___ Please complete the attached form for FMLA/disability leave. I authorize the release of supporting medical records to supplement my leave claim.

___ I am requesting leave starting: _____
(1st day of Leave)

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Tennessee Code 63-2-102.

Medical Records Copies:
Sharecare has set a cap of $25.00 plus postage (if applicable).

FMLA/Disability Forms Completion:
A fee of $15.00 per form is due at the time of submission.

Records being sent to another healthcare provider will be sent at **no** cost.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ (*Please Initial)*

I understand that: I may refuse to sign this authorization, and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____. *If I do not specify expiration, this authorization will expire in 1 year.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

Complete by WTBJC staff:

Payment: □ NC-Continuation of Care □ Bill from Bactes □ $_____ Form(s)