



**SOUTHERN  
JOINT  
REPLACEMENT  
INSTITUTE**

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

DATE: \_\_\_\_\_

Southern Joint Replacement Institute is authorized and requested to give \_\_\_\_\_, any and all information they may request regarding any physical condition and any treatment which has been rendered to me, including diagnosis and prognosis, and allow the above-mentioned to see and copy any and all records available, including x-rays, regarding my condition and treatment and/or all of my hospital records and charts.

This authorization is valid for six (6) months from the date of execution.

EXECUTED the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in Nashville, Tennessee.

Please check below who is receiving the records:

Personal Use \_\_\_\_\_

Doctor's Office \_\_\_\_\_

Insurance Company \_\_\_\_\_

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SSN

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*\*Please allow 10 to 14 days, from date of request, for medical records to be processed and mailed.\*\*