JOINT
Replacement Institute

TO RELEASE MEDICAL RECORDS FROM JRI AUTHORIZATION

Date: _____

Patient Name: _____DOB: _____SS#: _____

I Hereby Authorize: Joint Replacement Institute

To release copies of the following:

_____Medical Records _____Medical Records & X-Rays _____X-Rays _____Psych Eval

_____HIV/AIDS Treatment _____Hepatitis C Testing _____Alcohol/Drug Abuse Eval

To: _____

_____

_____

Purpose of Release: _____Continuing Care _____Insurance _____Litigation _____Personal

This Authorization expires on the following date: _____(If no date is specified, this release expires one (1) year from today's date.)

I understand there will be a $10.00 charge for x-rays and agree to pay for the copies at the time of pick-up.

_____

Patient Signature