Arthritis & Osteoporosis Consultants of the Carolinas

1918 Randolph Road
Charlotte, NC 28207
Phone: 704-342-0252
Fax: 704-342-1853

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Arthritis and Osteoporosis Consultants of the Carolinas to receive and/or disclose certain protected health information (PHI) about me.

Information Disclosed FROM:

Name: ____

Address: ______________________________________

City: ______________________State:_____Zip:_______

Telephone Number: ______________________________

Information Disclosed TO:

Name: ___________________________________

Address: _________________________________

City: __________________State:_____Zip:_______

Telephone and/or Fax: _______________________

This authorization Permits Arthritis and Osteoporosis Consultants of the Carolinas to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type(s) of service, level of detail to be released, origin of information etc.):

☐ History & Physical ☐ Radiology Report ☐ Other __________________________

☐ Progress Note ☐ Laboratory Report

☐ Consultation ☐ Entire Record

This information will be used or disclosed for the following purpose:

☐ Continuing Treatment ☐ Insurance ☐ Worker's Compensation

☐ Legal Investigation ☐ Disability Determination ☐ At the Request of the Patient

☐ Reason for Record Transfer: ____

If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on

____

The Practice will _____ will not __X__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Arthritis and Osteoporosis Consultants of the Carolinas. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed Pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization, in writing, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at:

1918 Randolph Road, Suite 600 Charlotte, NC 28207

____

Signature of Patient or Legal Guardian Relationship to Patient

____

Patient's Name So. Sec. # Date

____

Print Name of Patient or Legal Guardian Date of Birth

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION.

Please mail, fax or send via unsecured email to aoccinfo@gmail.com