Arthritis & Osteoporosis
Consultants of the Carolinas

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

Information Disclosed **FROM**: Information Disclosed **TO:**

Name: _____

Address: _____

Address: _____

City: _____ State: _____ Zip: _____ Telephone and or Fax: _____

Telephone Number: _____

This authorization permits Arthritis & 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 services, type(s) of service, level of detail to be released, origin of information, etc.):

History & Physical
Last year of Records
Last 2 years of Records
Consultation
Radiology Report
Laboratory Report
Other

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

Continuing Treatment
Legal Investigation
Insurance
Disability Determination
Worker's Compensation
At the Request of 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 one year from the date of signature.**

The Practice will will not 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 & 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. # (optional) 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