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Suite 600
Charlotte, NC 28207

AOCC
Arthritis & Osteoporosis Consultants of the Carolinas
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7810 Ballantyne
Commons Pkwy
Suite 300
Charlotte, NC 28277

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 myself.

Information Disclosed FROM:

Name:_____
Address:_____
Address:_____
City/State:_____ Zip:_____
Telephone:_____
Fax:_____

Information Disclosed TO:

Name:_____
Address:_____
Address:_____
City/State:_____ Zip:_____
Telephone:_____
Fax:_____

This authorization permits Arthritis & Osteoporosis Consultants of the Carolinas to use and/or disclose the following individually identifiable information about myself.

Specifically describe the information to be used or disclosed, such as date(s) of service, type(s) of service, level of detail to be releases, origin of information, etc.:

- ☐ Most recent office visit
- ☐ Last 1 year of records
- ☐ Last 2 years of records
- ☐ Radiology reports
- ☐ Lab reports
- ☐ Infusion records
- ☐ Patient demographics
- ☐ Entire record
- ☐ Other:

This information will be used or disclosed for the following purpose (If requested by the patient, purpose may be listed as "at the request of the patient"):

- ☐ Continuing treatment
- ☐ Insurance
- ☐ Legal Investigation
- ☐ Workers Compensation
- ☐ At the Request of the Patient
- ☐ Other

I do not have to sign this authorization in order to receive treatment from Arthritis & Osteoporosis Consultants of the Carolinas. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I have the right to revoke this authorization in writing at any time, 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 Rd, Suite 600 Charlotte, NC 28207

Patient Name (Printed) Date of Birth

Signature of Patient or Legal Guardian Date of Signature

Name of Legal Guardian if Applicable (Printed) Relationship to Patient

Please mail, fax, or send via unsecured email to info@aocc.md