1918 Randolph Rd
Suite 600
Charlotte, NC 28207

AOCC Arthritis & Osteoporosis Consultants of the Carolinas

Phone: 704-342-0252 Fax: 980-533-7807

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 released, 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 and/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

Patient's Rights:

- I have the right to revoke this authorization at any time in person or in writing.
- I may inspect or copy this protected health information to be disclosed as described in this document.
- Revokation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

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