ASHEVILLE ARTHRITIS
AND
OSTEOPOROSIS CENTER

PATIENT INFORMATION CONSENT FORM

I have received a copy of Asheville Arthritis and Osteoporosis Center's (AAOC) Notice of Privacy Practices. AAOC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment (TPO). With this consent, AAOC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care. AAOC may also mail to my home or other alternative location any items that assist the practice in carrying out TPO. I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. AAOC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

With this consent, I grant AAOC permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____ Date of Birth: _____

Signature of Patient : _____
Or
Legal Guardian: _____

Date: _____

Please list any other persons that you authorize to have access to your medical records.

Name	Relationship
Name	Relationship
Name	Relationship