Asheville Arthritis & Osteoporosis Center, P.A.
4 Vanderbilt Park Dr., Suite 200
Asheville, N.C. 28803
(828) 258-9533 Fax (828) 253-4434

Authorization for Release of Medical Information

Patient Name: ___________________________________ Date of Birth: ______________

Address: ___________________________________ City/State/Zip: __________________

Patient Phone: ______________________

Records to be released to: ____
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Records to be disclosed relates to service date(s): ________________________________

___ Physician Office Visit ___ Test Results (labs) ___ Bone Density Report ___ X-Ray Report

___ X-Ray imaging disc ___ Entire Medical Record ___ Other: ______________________

I hereby authorize disclosure of the health information for the above patient. I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state regulations. I understand that I have the right to revoke this authorization by sending a written notification to the address below, but that will not affect any information released prior to notification of cancellation. I understand that I have the right to inspect or copy the protected health information as described in this document. Written notification must be sent to Asheville Arthritis, Attn: Privacy Office, 4 Vanderbilt Park Dr., Suite 200, Asheville, NC 28803. This authorization is valid for 12 months from the date of the signature.

____ ____________________________

Signature of Patient or Guardian or Personal Representative | Date