

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: FROM AOA

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____
(Please circle preferred phone)

Email Address: _____

Dates of service requested for release: All dates Date range: _____ to _____

Information to be disclosed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Physical Therapy Reports | <input type="checkbox"/> Surgery Documentation |
| <input type="checkbox"/> Radiology Reports
(X-Ray, CT, MRI, Ultrasound) | <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> All of the above |
| | <input type="checkbox"/> X-Ray/ MRI images | <input type="checkbox"/> _____ |

Obtain information from:

Name: Asheville Orthopaedic Associates
Address: 111 Victoria Road
City: Asheville State: NC Zip: 28801
Phone: 828 252-7331
Fax: 828 213-2821

Disclose information to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____
Fax: _____

Reason for Release: Legal Move Consult/Second Opinion Personal

Authorization

I authorize Asheville Orthopaedic Associates to release the information marked above to the recipient. I understand I may revoke this consent at any time and that the consent will automatically expire one year from the date of my signature. I do not authorize release to a third party. I understand that once information is released under this authorization, Asheville Orthopaedic Associates has no further control of said information.

Authorized Requestor Signature: _____ Date: _____

NOTE: Federal and state laws regulate fees for copying records. Please allow 7 to 10 business days for records release. Questions may be directed to Asheville Orthopaedic Associates at 828-252-7331.

Please tell AOA if you need copies of your x-rays and/or MRI images. The fee for copying x-rays and/or MRI images to a compact disc (CD) is \$10.00 per CD.

OFFICE USE ONLY

Date Records Copied: _____ Copied by: _____

Medical Copies sent via: Mail Patient Pickup Fax to _____