ASHEVILLE ORTHOPAEDIC ASSOCIATES

setting the pace of orthopaedic care

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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:

☐Office Visit Notes ☐Consultation Reports ☐Pathology Reports

☐Laboratory Reports ☐Physical Therapy Reports ☐Surgery Reports

☐Radiology Reports ☐Workers Compensation ☐All of the above

(X-Ray, CT, MRI, Ultrasound) ☐X-Ray/ MRI images ☐_____

Obtain information from:

Name: Asheville Orthopaedic Associates

Address: 111 Victoria Road

City: Asheville State: NC Zip: 28806

Phone: (828) 252-7331

Fax: (828) 253-1123

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
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Medical Copies sent via: ☐Mail ☐Patient Pickup ☐Fax to _____