AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to release the following information from the medical record (Protected Health Information) of:

Patient Name:_____ Phone:_____

Address: _____

_____

Date of Birth: _____ Social Security#:_____

Information to be released to Carolina Orthotics and Prosthetics, LLC.

_____

_____

Purpose of disclosure: _____

An adult patient must sign for him or herself unless a guardian has been appointed by a court of law (legal representative in certain circumstances). If patient is unable to sign, he or she must make a mark (X) and have the signature of two witnesses.

I understand that I may; revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on any actions taken before receiving the revocation.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian Representative/Relationship Date

_____ _____

Signature of Witness Date