INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my permission to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily.

Individual Patient's Name: _____

Your address: _____

Your Telephone Number: _____

Your E-Mail Address: _____

Your Social Security Number: _____

2. DISCLOSURE INFORMATION

The information contained in my chart and/or provided to the practitioner by me, may be disclosed to my physician, physical therapist, and/or their assistant or office staff for purpose of providing the appropriate orthosis/prosthesis. It may also be disclosed to any company that may be involved in the processing of the claim submitted by this provided to secure payment for services rendered.

3. REVOCABLE CLAUSE

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

4. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected information described in this form with the people and/or organizations named in this form.

Signature _____ Date _____

Print name _____

Personal Representative's Name: _____
Print name

_____
Signature

Relationship to Individual Patient: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Official and include a copy in the individual patient's medical record.