



AUTHORIZATION TO RELEASE HEALTHCARE

PRINTED NAME OF PATIENT

PREVIOUS NAME, IF APPLICABLE

DATE OF BIRTH

DAYTIME PHONE NUMBER

I understand that once Brownfield's Prosthetic & Orthotic Technologies disclose health information, the person or organization that receives it may re-disclose it, at which time may no longer be protected under Privacy Laws. I also understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

SEND INFORMATION TO:

Provider/Name Organization

Address:

Phone #: Fax #:

INFORMATION TO BE RELEASED FROM:

Provider/Name Organization

Address:

Phone#: Fax#:

PURPOSE OF DISCLOSER:

Transfer of care Personal Legal

INFORMATION TO BE DISCLOSED:

Medical records within last 2 years Other (List Specifics & Date Range)

SIGNATURE OF PATIENT OR REPRESENTATIVE RELATIONSHIP DATE

This authorization expires 90 days after it is signed. This authorization may be revoked in writing.

Witness: Date: