Brownfield's
PROSTHETICS & ORTHOTICS *restoring independence | renewing lives*

AUTHORIZATION TO RELEASE HEALTHCARE MEDICAL RECORDS

Patient Name (please print) _____ Previous Name (if applicable) _____

Patient Date of Birth _____ Patient 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 release from:
Provider/Name Organization: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose of disclosure:

_____Transfer of care _____ Personal _____ Legal _____ DME

Information to be disclosed:

_____ Medical record within last year _____ 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:** _____

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