Northern Prosthetics & Orthopedic, Inc.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient: ______________________________ **Date:** ___/___/___

This form will authorize Northern Prosthetics & Orthopedic, Inc. to release information to those who are listed below. We will not discuss or release any protected health information to anyone other than your insurance provider and others who are involved in your treatment or reimbursement unless the individual is listed on this document. It is understood that this authorization may be revoked at any time, if requested in writing, except to the extent that action will have already been taken.

I, ______________________, authorize Northern Prosthetics & Orthopedic, Inc. to release any and all records and written material, pertaining to the examination, treatment, etc. for ____________________.

Individual or organization to which information should be released (name & address):

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I, ___________________, authorize Northern Prosthetics & Orthopedic, Inc. speak to or leave a voice message for me or the following listed names on my answering machine or voice mail.

Name_________________________________ contact # _______________

I hereby waive and release Northern Prosthetics & Orthopedic, Inc. from any restrictions imposed by law in disclosing any professional records, observation or communication to:

Patient signature _________________________ Date Signed ____/_____/______

Date of Birth ____/_____/______