**ORTHOTIC & PROSTHETIC CENTER**

***Authorization to Release Medical Information***

I authorize the named health care provider to release the information or records specified to Orthotic & Prosthetic Centers (“OPC”) upon request either in person or by mail to the address provided at the time of the request.

|  |  |
| --- | --- |
| **Provider: (name and address)** | **Patient:**  **SS#:**  **DOB:** |

**Records authorized to be released:**

€ Admission history and physical € Lab reports

€ Discharge summary € Radiological images

€ Complete medical chart € Consultation notes or reports

€ Office notes € Complaints or grievances filed, with responses or

€ Outpatient records dispositions

€ Psychiatric and other mental health records

€ Records relating to drug or alcohol abuse (must specify extent or nature of the records to be released)

€ Medication administration logs, dietary logs, staff contact or service logs, and other records that may

not be part of my individual medical record, but which contain information relating to me. (These

records should be redacted to protect information pertaining to other patients.)

€ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information will be used for the purpose of:**

€ Verifying my eligibility for services offered

€ Other activities at the request of the individual

**This authorization will expire one year from the date of the signature below**. I understand that I can revoke this authorization at any time by writing to the health care provider or to OPC, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I also understand that:

* My healthcare or payment for my healthcare will not be conditioned on the signing of this authorization.
* Federal privacy regulations will no longer apply to the information disclosed, and that may re-disclose the information.
* I am entitled to receive a copy of this authorization.
* A copy of this authorization may be utilized with the same effectiveness as an original.

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Signature of Patient or Guardian Date

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Printed Name of Patient or Guardian Relationship to Patient