Authorization to Obtain/Release Protected Healthcare Information

I hereby authorize Southeastern Orthotics and Prosthetics to obtain protected medical information or other documentation required by them or my insurance company from my physician or other healthcare provider for my care, evaluation or treatment.

I also authorize Southeastern Orthotics and Prosthetics to release my protected medical information to my insurance company, physician or other health care provider for my care, evaluation or treatment provided by Southeastern Orthotics and Prosthetics.

I understand I am not required to sign this document and that I may revoke my authorization at any time (except to the extent that the information has already been released). However, I also understand that Southeastern Orthotics and Prosthetics may not be able to provide care to me if my care requires protected medical information being obtained from, or released to, my physician, other healthcare provider or insurance company.

_____

Signature of Patient, Parent/Guardian Date

_____

Relationship to Patient (Parent/Guardian, etc.)

Please check box and initial if you do not authorize release of protected health information.

☐ Patient declines release of protected health information. _____