Prosthetic & Orthotic Solutions, LLC.

Authorization to Release Medical Records & Protected Health Information

(Patient's Printed Name)	**MRN#** (office use)

Patient's Address	Date of Birth

Telephone Number	Social Security #

Permission to Share: I give my permission to share my protected health information.

From:	**To:**
	Prosthetic & Orthotic Solutions, LLC.
	66 Myron Street
	West Springfield, MA 01089
	p. 413-785-4047
	f. 413-785-4048
	Contact: Medical Records

Purpose: Medical Care Relating to Diabetic Footwear, and any/all Orthotic and Prosthetic Devices.
Information to be Released: All Office Notes, Medical Records, Consults, and Operative Reports that may relate to the patients need for Diabetic Footwear, and any/all Orthotic and Prosthetic Devices.

Date(s):

I understand and agree that:

- This authorization is voluntary
- I may cancel this authorization at any time by submitting a written request to the requesting party, except if they have already relied upon it (for example, once information is released or received)
- My questions about this authorization form have been answered
- Prosthetic & Orthotic Solutions, LLC. cannot control how the recipient uses or shares the information if they are party forwarding the information, and that laws protecting its confidentiality at P&O Solutions may or may not protect this information once it has been released.

Patient or Responsible Party Signature	Date

If Responsible Party, please complete below:

Printed Name

Address

Relationship to Patient

For Notice of Privacy Practices only, describe the Responsible Party's authority to act on behalf of the patient.