



## Compound Authorization for Release of Information

PATIENT NAME \_\_\_\_\_ Date \_\_\_\_\_

Please check either "Yes" or "No" and initial each line: **Do you authorize Prosthetic and Orthotic Institute to:**

1. Mail medical reports through US Postal Service? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial
2. Leave a message on Voice Mail? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Cell Phone Number \_\_\_\_\_
3. Leave a message on Answering Machine? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Home \_\_\_\_\_ Work \_\_\_\_\_
4. Give information to your employer? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Name \_\_\_\_\_
5. Give information to your school? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Name \_\_\_\_\_
6. Give information to your spouse? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Name \_\_\_\_\_
7. Give information to your parents? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Name \_\_\_\_\_  
Name \_\_\_\_\_
8. Give information to your children? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Name \_\_\_\_\_  
Name \_\_\_\_\_  
Name \_\_\_\_\_
9. Give information to friends or others? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Initial  
Name \_\_\_\_\_  
Name \_\_\_\_\_

### Rights of the Patient

1. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed in this document by signing a written notification to **Prosthetic and Orthotic Institute HIPAA Officer**.
2. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
3. I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
4. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Print Name of Patient \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

POI Employee \_\_\_\_\_ Time \_\_\_\_\_