PROSTHETIC
ORTHOTIC
INSTITUTE

Prosthetic and Orthotic Institute
Authorization for Release of Information

Patient Name: _____ DOB: _____ SS#: _____

Person/Organization Receiving the Information:
Prosthetic & Orthotic Institute
223 S. Herlong Ave. Ste 110
Rock Hill, SC 29732
(Tel) 803-908-5080
(Fax) 803-980-5083

Person/Organization Providing the information:

_____
_____
_____

PATIENT INFORMATION IS NEEDED FOR:

Insurance Authorization Medicare Requirement

INFORMATION TO BE RELEASED OR ACCESSED:

Evaluation & Office Notes

Financial

Other_____

Please fax all requested information to: 803-980-5083

Rights of the Patient

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.**

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

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.

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.

Patient Signature or Patient's Representative_____ Date: _____

If signed by patient's representative, relation to patient (description to act):

_____
_____