

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION TO:

CREATIVE PROSTHETICS & ORTHOTICS, LLC

I, _____ SS# _____
(Print patient 's name) (Social Security number)

Medicare/Insurance ID#: _____

By my signature below I give my permission for the receiver of this document to share my medical records/information with Creative Prosthetics & Orthotics, LLC. The information will be used only for sharing with other health care providers as needed, insurance processing or review, legal reasons or other reason(s) specified below:

Other: _____

This medical release document will be enforce from the date entered below and will terminate upon receipt of written notification.

Patient or Legal Guardian Signature

Date

Legal Guardian printed name

Relationship to Patient