AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION TO:

CREATIVE PROSTHETICS & ORTHOTICS, LLC

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

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 enforced from the date entered below and will only terminate upon receipt of written notification.

_____ _____
Patient or Legal Guardian Signature Date

_____
Legal Guardian printed name

_____
Relationship to Patient