AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Excel Prosthetics and Orthotics

Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: Orthotic and Prosthetic Devices

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date Signed: _____

POA Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.