FOURROUX PROSTHETICS *Building Relationships for Life*

Authorization To Release Medical Records

Patient Name: _____ DOB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Release To:

Physician Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Medical Records should include:

- ☐ Physical Exam(s)
- ☐ Treatment and/or Assessment Note(s)
- ☐ Billing Notes
- ☐ Other: _____

I hereby request and authorize the physician listed above to obtain my medical records and related information to Fourroux Prosthetics, Inc., for the purpose of providing medical care and treatment to me.

My restrictions to this authorization are limited to the information indicated above.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing. No revocation is given if authorization has already been relied upon to obtain services.
4. If the requestor or receiver is not a health plan or provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. The purpose for the release of these records is healthcare related.

This authorization is valid for five (5) years from today's date, unless revoked in writing beforehand.

_____
Print Name

_____ _____
Patient / Authorized Signature* **Date**

_____
***Relationship to Patient**