FOURROUX PROSTHETICS *Building Relationships for Life*

Authorization To Release Medical Records

Patient Name: _____ DOB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Release To:

Name: _____ DOB: _____ 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 Fourroux Prosthetics, Inc. to release my medical records and related information to the above mentioned for the purpose of providing medical care and treatment to me.

My restrictions on 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.

Insurance Authorization / Release Form

Release To:

Name: _____ DOB: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the use of this form on all my insurance submissions.

Fourroux Prosthetics, Inc. shall act as my agent in helping me obtain payment from my insurance companies, including obtaining medical records from other physicians and/or medical providers which may be requested by my insurance companies.

I understand that my signature requests that payment be made and authorizes release of medical information to my insurance companies, necessary to process the claim, with payment to be made to ***Fourroux Prosthetics, Inc.***

Photograph / Social Media

Consent & Release

- ❑ I **consent** to the participation of interviews, use of quotes, photographs and/or videos by Fourroux Prosthetics, Inc. Fourroux Prosthetics, Inc. has the
  the right to edit, use, and reuse images and/or videos in, but not limited to, print publications, online publications, presentations, websites, and social
  media. I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.
- ❑ I **do not consent** to the participation of interviews, use of quotes, photographs and/or videos by Fourroux Prosthetics, Inc.

Acknowledgement / Consent

I acknowledge I have been provided with a copy of Fourroux Prosthetics' Notice of Privacy Practice.
I acknowledge I have been provided with a copy of Fourroux Prosthetics' Patient / Guest Code of Conduct Policy.
I acknowledge I have been provided with a copy of Fourroux Prosthetics' Office Financial / Equipment Warranty Policy.
I consent to the release and use of my protected health information as HIPAA permits.

_____	_____	_____	_____
Print Name	**Patient / Authorized Signature***	***Relationship to Patient**	**Date**