J & J Artificial Limb & Brace
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Authorization for Use of Protected Health Information

Patient Name: _____ DOB: _____
Address: _____ Phone: _____
_____

Authorization to obtain Medical Information

I, _____ authorize J & J Artificial Limb and Brace to obtain medical records from:

Records Release From:
_____
_____
_____
_____

For the following Dates: _____
Purpose of discloser:
___Further Medical Care ___Legal Investigation
___Payment of Insurance ___Appeal
___Request for Authorization ___Attorney Inquiry
___Other: _____

Information to be Released:
Pertaining to**:** _____
___Complete Copy of All Records ___Allergy Records ___X-ray Reports
___History & Physical Report ___OT/PT Report ___Physician orders
___Physicians Progress Notes ___Other: _____

This authorization will remain in effect for an unspecified time period or until I revoke this authorization in written to J & J Artificial Limb and Brace.

Disclosure of Medical Information

I authorize J & J Artificial Limb & Brace to disclose my health information specific to the following date of time period: UNTIL OTHERWISE NOTIFIED. The individual or entity authorized to receive my health information are THERAPIST, DOCTOR, MEDICAL INSURANCE AND CASE WORKER, DEPARTMENT OF HEALTH SERVICES, and DEPARTMENT OF SOCIAL SECERITY. The purpose for which disclosure is to be made is for BILLING AND CALRIFICATION OF ORDERS. The information to be disclosed may be one or more of the following: Practitioner Summery, History & Physical Reports, Office Chart Notes, Consultation and prescription.

I understand that if the person(s) or entity (ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and is no longer protected by those regulations. Therefore I release J & J Artificial Limb & Brace, its employees, and my physicians from all liability arising from this disclosure of my health information.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revoke request. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____
Signature of Patient or Legal Representative Date