Rocco Prosthetic & Orthotic Center, Inc.

Authorization for Release of Medical Information

Patient Name		Maiden Name
Social Security Number	Date of Birth	Phone Number
Address		

Provider Making the Use or Disclosure: I authorize _____ (referred to as "Health Care Provider") to release my/the patient's individually identifiable health information as described below.

Recipient of the information: I authorize the release of my medical records or other health care information, including intake forms, exams, chart notes, correspondence, billing statements, and other written information concerning my health and treatment to be sent to the following person or company:

Rocco Prosthetic & Orthotic Center, LLC.
2375 Florence Avenue
Cincinnati, OH 45206

Dates of Treatment: (Check "All dates of treatment" or "Specific dates of treatment")

☐ All dates of treatment; *or*

☐ Specific dates of treatment: I only want records for the following dates of treatment to be disclosed:

_____

Purpose for the Use or Disclosure: The purpose for the disclosure is at the patient's request.

Oral Communication: I understand this Authorization allows the Health Care Provider (and its employees) to discuss my individually identifiable health information described herein with the recipient of the information.

X_____ **X**_____

Signature of Patient or Patient's Representative **Date**

Printed name of patient's representative, if applicable: _____

Relationship to patient:

☐ Parent ☐ Legal Guardian ☐ Other: _____