To: ____________________ Fax Number: ____________________

From: Howard Orthotics & Prosthetics, LLC Date: __________ No. of Pages: ______

Office Phone: (315) 786-8973 **Office Fax: (315) 786-7993**

*******CONFIDENTIAL FACSIMILE*******

This facsimile may contain individually identifiable patient health information or information which is confidential and solely for the person and entity named above. This use and disclosure of patient health information contained in this fax is restricted by the Health Insurance Portability and Accountability Act of 1995 and is protected under the Privacy Act of 1994. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of this information is prohibited. If you have received this fax transmission in error, please notify Howard Orthotics & Prosthics, LLC by telephone or mail and destroy this communication.

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION AND RECORDS

This authorization for use or disclosure of Protected Health Information is intended to satisfy the requirements of the Health Insurance Portability and Accountability Act (HIPAA) [45c.f.r. § 164.500 *et seq.* (2003)].

Please review and complete the authorization carefully. Failure to provide all of the requested information may invalidate the authorization.

I, ______________________, hereby authorize ______________________,
(Name) (Facility Name)

______________________, to disclose the protected health information and records of
(Facility Address)

Patient's Name:______________________**Patient's Date of Birth**:__________

To be released to: **Howard Orthotics & Prosthetics, LLC**
316 Sherman Street, Watertown, NY 13601-3614

For the purpose of:______________________

This authorization is limited to the following information relating to my past, present, or future physical or mental health or condition:

- ☐ **Military health record(s)**
- ☐ **Complete health record(s) and other records** for the following date of service, which may contain all of the documents listed below, as well as other notes/documents relating to my treatment: ______________________
- ☐ **Complete health record(s) and other records** for the following date of service, excluding the following records: ______________________
- ☐ **The following health records or other records:**______________________

EXPIRATION

This authorization shall be in force and effect for one year at which time this authorization to disclose this protected health information and records expires.

PATIENT'S RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Howard Orthotics & Prosthetics, LLC, 316 Sherman Street, Watertown, NY, 13601-3614. I understand that a revocation is not effective to the extent that the disclosing facility has relied on the use or disclosure of the protected health information. I understand that I have a right to receive a copy of this authorization upon my request.

SIGNATURE

______________________ __________
Signature of Patient or Personal Representative Date

______________________ __________
Signature of Witness Date