DANKMEYER
PROSTHETICS & ORTHOTICS

SPECIFIC AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize Dankmeyer, Inc. (Provider) to release information contained in my medical records, or to provide copies of my medical records as requested to:

NAME:___________________________ ADDRESS:____ FAX#:_______________

Medical Information to be released: ☐ All or ☐ Specific: ___________________________

Purpose of Authorization: ____

(Note: Patient may write "for Patient's own purposes")

Any restrictions that I wish to impose on this authorization are listed below: ________________

____

____

I understand the following:

1. That Provider will not refuse to provide treatment to me if I do not sign this Authorization.
2. That I may inspect or copy the information that is provided under this Authorization.
3. That if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations.
4. That my treatment is not conditioned upon my signing this Authorization.
5. That there is the potential that the person or entity to whom I am authorizing disclosure might further disclose the information to other persons (although they may be prohibited by law from doing so).

This authorization is valid from today's date until ____________________, unless I revoke the authorization through written notice to provider.

____
Name of Patient (Please Print)

____ ____
Date of Birth Daytime Phone Number

____ ____
Signature of Patient (or legally responsible party) Date

____
Description of Authority of legally responsible individual

Phone: (410)636-8114/(800)879-1245 Fax: (410)636-8325
825 N Hammonds Ferry Road, Suite D, Linthicum, MD 21090