MOPA, LLC
FAMILY O&P

Manfredi
Orthotic
Prosthetic
Affiliates, LLC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
(Protected Health Information)

I hereby authorize any provider of care to release copies of my medical information (Protected Health Information) of:

Patient Name: _____ Date: _____

Address: _____

Date of Birth: _____ Social Security #: _____

Beginning with start of care 2/18/14

Information to be released to: Manfredi Orthotic & Prosthetic Affiliates
749 Hope Road, Suite C
Eatontown, NJ 07724
(732) 380-0366 phone
(732) 380-0245 fax

The medical records requested are related to treatment including the written order, detailed prescription, and medical history related to the device prescribed.

The purpose of disclosure is to satisfy the Medicare documentation requirements for P&O services.

I, on behalf of myself or any other person who may have an interest in the matter, hereby release the facility, its employees, and officers from legal responsibility or liability in regard to the acts that I have hereby authorized.
A parent or court appointed guardian must sign for a minor.
An adult patient must sign for him or herself unless a guardian has been appointed by a court of law (legal representative in certain circumstances). If patient is unable to sign, he or she must mark (X) and have the signature of a witness.
I understand that this information will expire one year from the date of signature.
I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions taken before receiving the revocation.

I hereby consent to the release of the information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Representative/Relationship Date

_____ _____
Signature of Witness Date