Authorization to Disclose Information

Regarding Patient:________________________________ DOB:__________________

Requesting from Facility:______________________________

Please read the entire form before signing below.

The purpose of this signed authorization is to help determine eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet your insurance company's definition of eligibility for coverage and payment. American Orthopedics, Inc. may need to secure medical documentation from one or more of your physicians in order to provide your insurance company with the specific details they require in order to process your claim more quickly and accurately.

I, ______________________________ (please print), voluntarily authorize and request disclosure of all my medical records, including written, oral and electronic, or other information related to my ability to perform tasks pursuant to my PROSTHETIC and/or ORTHOTIC TREATMENT and CARE with American Orthopedics, Inc., 1151 West 5th Avenue, Columbus, Ohio 43212. This includes specific permission to release:

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s), including but not limited to:
   - Progress notes
   - Information relating to and including prescriptions
   - Hospital notes
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living and affect my ability to work and enjoy life.
3. Information created within twelve (12) months after the date this authorization is signed, as well as past information.

Please sign using blue or black ink only.
Individual authorizing disclosure:

____________________________ __________________
Patient Signature Date

____________________________ ☐ Parent ☐ Guardian ☐ POA
Authorized Signer

____________________________ __________________
Witness (if needed) Date

Address:____
Street City State ZIP County

MEDICARE PATIENTS ONLY Continue to Page 6 ►

Statement to Permit Payment of Medicare Benefits to Provider, Physician(s) and Patient

PROSTHETIC & ORTHOTIC SERVICES

Regarding Patient:______________________________________ DOB:____________________

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I require that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the medical insurance program be made to American Orthopedics, Inc., 1151 West 5th Avenue, Columbus, Ohio 43212 on any bills for services furnished to me by this company.

______________________________________ ____________________

Patient Signature (or Parent/Legal Guardian if a minor) Date