ALLIANCE
PROSTHETICS + ORTHOTICS

HIPAA Authorization Form

I authorize the following individuals to have full access to my health information:

Print Name Relationship Phone Number Date

_____

_____

_____

_____

I, _____, give my permission for you to leave any medical information for me at the following phone number/email addresses.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY POLICY.

Home #:	
Cell #:	
Work #:	
Email Address:	

_____ _____

Signature of Patient or Guardian Date

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