Orthotics & Prosthetics Labs, Inc.

James Haas, CO
Blaine Drysdale, CP, MSPT
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM OTHER PROVIDERS

Patient: _____ Account #: _____ Date: ___/___/____

This form will authorize:

Doctor: _____

Phone: _____

Address: _____

_____

To release information to those who are listed below. We will not discuss or release any protected health information to anyone other than your insurance provider and others who are involved in your treatment or reimbursement unless the individual is listed on this document.

I, _____, authorize (doctor's name) _____ to release any and all records and written material pertaining to _____ for continued care to be released to:

O & P LABS, INC

300 Birnie Ave, Ste. 303

Springfield, MA 01107

Phone: (413) 737-2404 Fax: (413) 733-1389

Patient Signature: _____ Date Signed ___/___/____

Date of Birth ___/___/____