



James Haas, CO  
Blaine Drysdale, CP, MSPT  
Ted Stelamt, BOCO  
Jeff Berger, COA  
Donna Connell, CFom

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 \_\_\_/\_\_\_/\_\_\_

**Springfield**

**Great Barrington**

**Northampton**

**Pittsfield**

300 Birnie Avenue - Suite 303

80 Maple Avenue - Suite 2

241 King Street - Suite 123

700 North Street - Unit 2

Springfield, MA 01107

GR Barrington, MA 01230

Northampton, MA 01060

Pittsfield, MA 01201

P 413.737.2404 F 413.733.1389

P 413.717.4240 F 413.717.4241

P 413.585.8622 F 413.587.3773

P 413.442.0017 F 413.442.0020

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