ADVANCED PROSTHETIC AND ORTHOTIC CENTER, INC.

502 WEST NOB HILL BOULEVARD, SUITE 1
YAKIMA, WA 98902
PHONE 509-249-0011 FAX 509-249-0077

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

YOU MAY DISCUSS MY HEALTHCARE INFORMATION WITH THE FOLLOWING FAMILY MEMBER(S)

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.