

**AUTHORIZATION
FOR RELEASE OF PRIVATE MEDICAL INFORMATION
Therapeutic Footwear for Diabetes**

Most insurers require recent progress notes from your foot exam as a requirement of benefits. Kindly fill out the form, sign and date it on page 2 and present it to the office for the clinician who examines your feet.

SECTION I

First Name

Last Name

I, _____ Date of Birth ____/____/____, give my permission for my doctors to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II - Health and Personal Information

Please describe the information you want your doctors to share about you. Please include any dates and details you want to share.

Most recent clinical progress notes from my visit with the MD, DO, NP or PA who performed a recent foot exam:

Name

Credential

Organization

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information.

- Insurer required clinical documentation for prescribed, therapeutic footwear.

SECTION IV – Who May Share This Information

I give permission to the person or organization listed in Section II above to share the information I listed in in the same section:

SECTION V – Who May Receive My Information

The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

Organization: Boston Pedorthic

Fax Preferred: 270-747-8779

1929 Commonwealth Avenue, Brighton MA 02135 Tel: 617-787-8779

SECTION VI- How Long This Permission Lasts

This permission to share my information is good for 5 years.

I understand that I can change my mind and cancel this permission at any time. To do this, I can choose from these delivery methods: 1) to send a text to 617-787-8779, 2) an email message to info@bostonpedorthic.com, write a letter and 3) mail it, or 4) fax it to Boston Pedorthic. If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION VII – Signature

Please sign and date this form, and print your name.

Your Signature

Printed Name: _____ Date: / /

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court-appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form:

Signature of the person filling out this form:

Describe how this person has legal authority for this individual:
