



343 S. Kirkwood Rd. Suite 200, Saint Louis MO 63122
Phone: 314-262-8900 Fax: 314-743-3575

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: Premier Prosthetics and Orthotics, LLC

Address: 343 S. Kirkwood Rd. Suite 200

City: St. Louis State: MO Zip Code: 63122

This request and authorization applies to:

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

☐ All healthcare information

☐ Other: _____

This authorization can be revoked at any time in writing by the patient.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 36 MONTHS AFTER IT IS SIGNED.

