AUTHORIZATION
FOR RELEASE OF PRIVATE MEDICAL INFORMATION
Therapeutic Footwear for Diabetes

Most insurers require recent progress notes from your diabetes 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 manages your diabetes.

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 manages my diabetes:

Name Credential Organization

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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.

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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:

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Signature of the person filling out this form:

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Describe how this person has legal authority for this individual:

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