HORIZON PROSTHETICS

HIPAA AUTHORIZATION FORM

I, _____, give permission to **Horizon Prosthetics** to:

_ Use the following protected health information, and/or

_Disclose the following protected health information to: _____
[Company Releasing Information To]

_Leave detailed clinical information on my voicemail, and or

_ Leave detailed clinical information with a spouse/ family member _____

phone # Authorized to leave messages_____

Information to be disclosed (check all that apply):

_ Medical Records
_ Treatment Records
_ Diagnostic Records
_ Other: _____

This protected health information is being used or disclosed for the following purposes:

_____
_____

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits. You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed. Finally, you may revoke this authorization in writing at any time by sending written notification to Kelli McKenna at 8232 Park Meadows Drive, Lone Tree, CO 80124. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____ _____
Signature of Participant or Personal Representative Date

_____ _____
Printed Name of Participant or Personal Representative Description of Personal Representative's Authority

Horizon Prosthetics LLC
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