TANDEM ORTHOTICS & PROSTHETICS, INC.

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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: __ Tandem Orthotics & Prosthetics Inc.___
Address: _2380 Troop Drive Suite 204__
Sartell, MN 56377

This request and authorization applies to:

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

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☐ All healthcare information

☐ Other: ____

Definition: Sexually transmitted disease (STD) as defined by Minnesota Department of Health includes Acquired Immunodeficiency Syndrome (AIDS), Bacterial Vaginosis (BV), Chancroid, Chlamydia, Genital Herpes, Genital Warts/HPV, Gonorrhea, Hepatitis A and B, Herpes Simplex Virus, Human Immunodeficiency Virus (HIV), Human Papillomavirus (HPV), Lymphogranuloma Venereum (LGV), Molluscum Contagiosum Virus (MCV), Nongonococcal Urethritis (NGU), Pelvic Inflammatory Disease, Pubic Lice (crabs), Retrovirus infections other than HIV, Scabies (mites), Syphilis, and Trichomoniasis.

☐ 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 tests 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: ____________________________