Heartland O&P Inc.
919 Westport Pl.
P: 785-320-2320
F: 785-320-2321
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AUTHORIZATION TO RELEASE HEALTHCARE

Patient's Name:_____ Date of Birth:_____

Social Security #:_____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

This request and authorization applies to:

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

_____

○ All healthcare information:

_____

○ Other:

_____

Patient Signature:_____ Date:_____