PRO rthotics & OT, LLC

RELEASE TO ACCESS, PRINT AND SAVE IMAGING RESULTS

Patient's Name: _____
Last First Middle

Parent/Guardian Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ **Patient's Date of Birth:**_____

INFORMATION AUTHORIZED TO BE USED AND DISCLOSED: I authorize PR Orthotics & OT, LLC ("the Company") and others it may authorize to access my child's radiology images. . I also authorize the Company to use and disclose such images for medical treatment and fabrication of orthoses.

TERM: This Authorization will be effective for twenty five (25) years from the date signed unless I submit a written notice of revocation to the Company at the address below. The revocation will be effective immediately upon receipt, except that the revocation will not have any effect on any action taken before receipt of my written notice of revocation. The images will be held in my child's medical record at PR Orthotics & OT LLC.

PURPOSES AND RECIPIENTS: The information identified above may be used or disclosed under this Authorization for

☐ YES or ☐ NO Fabrication of custom orthoses

☐ YES or ☐ NO Submission to insurance companies as needed

☐ YES or ☐ NO Documentation records.

I also release, discharge, and agree to hold the Company harmless from any and all claims of any kind which I, my heirs, executors, and assigns may have arising out of or in connection with the Company's use of the patient's imaging studies pursuant to this Authorization.

I may contact PR Orthotics & OT, LLC at any time care of Patricia Rogel, Director, 4711 Golf Road, Suite 1055, Skokie, IL 60076-1224. Or I can call 224-470-8550, if I have any questions about this Authorization.

I have read and understand the terms of this Authorization and had an opportunity to ask questions about the use and disclosure of radiograph information about the patient. By my signature, I authorize the uses and disclosures of information about the patient as described above.

_____ _____ _____
Signature of Parent or other Personal Representative (or Patient if of legal age) | Relationship to Patient | Date of Signature