

OrthoPro Services LLC

Specializing in orthopedic braces and artificial limbs

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Phone: 478-272-6522
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Patient Information Release

I hereby grant permission for OrthoPro Services, LLC to receive pertinent medical records from any of my health care professionals. These records once received will only be used to establish medical necessity for my orthotic/prosthetic device. I understand that records received may also be forwarded to my insurance company when needed.

I authorize that a copy of this release will be valid as the original. This release will be valid until rescinded in writing.

Patient's Name (Printed) _____ DOB: ___/___/___

Signature: _____ Date: _____

For patient's under 18:

Parent or Guardian Name (Printed) _____

(Parent or Guardian)Signature: _____ Date: _____