Authorization for the Release of Protected Health Information

Patient Name: _____
Healthcare Facility Making Disclosure ("HCF"): _____

I hereby authorize HCF to release the following information (please check one):

☐ **My name, contact info, mailing address, level and/or cause of amputation; or**

☐ **The following limited information: _____**
(please describe the information you wish to disclose)

to the Amputee Coalition for the purpose of receiving additional education materials from the Amputee Coalition to assist in my recovery and adjustment after amputation, as well as to receive a peer visit from an Amputee Coalition Certified Peer Visitor, if I choose. I understand that the information specified above will be disclosed pursuant to this Authorization. I understand that I have the right to: inspect or copy the protected health information to be used or disclosed as permitted under Federal or State law; refuse to sign this Authorization; receive a copy of this Authorization; and revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it by HCF. I further understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information and may no longer be protected by Federal or State law. I understand that HCF will not condition treatment, payment, enrollment or eligibility for benefits on whether the I sign the Authorization. This Authorization will expire one year from the date of signature below.

By signing your name below, you acknowledge that you have read and agree to the terms of this Authorization.

Signature: _____ Date: _____

If the Patient is a minor or unable to sign, then his/her Legal Representative gives the above consent on the Patient's behalf.

Signature: _____ Date: _____

***You may opt out of further contact with the Amputee Coalition at any time by writing the Amputee Coalition at info@amputee-coalition.org to make the request.**

Patient Name:
Patient Age:
Patient Gender:
Patient Race/Ethnicity:
Patient Mailing Address:
Patient Email Address:
Patient Phone Number:
Level and Cause of Amputation: