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## **Consent for the Disclosure of Health Information with Additional Individuals**

By signing below, you grant permission to Miller Prosthetics & Orthotics, LLC, our staff and our business associates to discuss your health information with the individual(s) listed below.

Name	Relationship to Patient
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

*Signatures are digitally captured in OPIE HIPAA Patient Documents & Supplier Standards*