Myomo, Inc., Release of Medical Records and Designation as Representative for Insurance Appeals

I, ____, certify that I am seeking treatment for orthotic care by orthotic provider ________________________________ and ***Myomo, Inc***. As such I recognize they are both covered entities under HIPAA, with legitimate needs to access my medical records and responsibilities to protect my privacy. I knowingly release to both of them any and all medical records required to ascertain the medical necessity of the care being provided to me, as well as any and all medical records required to pursue insurance coverage for those services.

Patient Signature: ____ Today's Date: _____________

Printed Name: ____ Date of Birth: _____________

Parent/Legal Rep (if patient cannot sign):_________________________________ Date:______________

Authorization and Designation of Insurance Representative

I, ____, do hereby designate, authorize and convey to orthotic provider ________________________________ , and ***Myomo, Inc.***, to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, the right and ability to act on my behalf in connection with any appeal for denied proposed healthcare services (e.g. prior authorization) or denied claim for said services that I may have under such insurance policy and/or any employee health care benefit plan – including but not limited to, the right to act in my behalf in respect to an employee health care benefit plan governed by the Employee Retirement Income Security Act of 1974.

Patient Signature: ____ Today's Date: _____________

Printed Name: ____ Date of Birth: _____________

Parent/Legal Rep (if patient cannot sign):_________________________________ Date:______________