STEVENS POINT ORTHOPEDICS

Dr. James Banovetz, PhD
Dr. Thomas Guse
Dr. Marcus Haemmerle
Dr. David Henneghan
Dr. Joshua Troyer
Dr. Todd Williams

World Class Treatment... Hometown Care

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY MEMBERS OR FRIENDS WHO MAY BE INVOLVED WITH MY CARE OR TREATMENT.

_____ _____
Name of Patient Birth Date

_____ _____
Street Address City, State & Zip Code

I hereby authorize: Stevens Point Orthopedics
500 Vincent Street
Stevens Point, WI 54481
Ph. 715-344-0701 Fx. 715-344-4494

To release the following protected health care information. YOU MUST CHECK ONE OF THE CHOICES BELOW or nothing can be released.

_____ Medical & Billing _____ Medical Only _____ Billing Only

☐ None, I am the only person who is to have access to my medical and billing information.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand this authorization will remain in effect indefinitely unless I notify Stevens Point Orthopedics in writing of the revocation.

□ In lieu of my death, this authorization will be null and void.