James Banovetz MD, PhD
Thomas Guse MD
Marcus Haemmerle MD
Mark Jordan MD
Joshua Troyer MD
Todd Williams MD

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 Date of Birth

____________________________________ _______________________________
Street Address City, State & Zip Code

I hereby authorize: Stevens Point Orthopedics | 500 Vincent Street, Stevens Point, WI 54481

Phone: 715-344-0701 | Fax: 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

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

☐ **In the event of my death, this authorization will be null and void.**

____________________________________ _______________________________
Signature of Patient Date