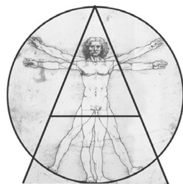

ORTHOPAEDIC ASSOCIATES
OF WAUSAU S.C.

DISCLOSURE OF RECORDS

This form is intended to identify those individuals (family members, close friends, or other persons) to whom we can disclose your protected health information or notify them regarding your care. This form will remain in force until you provide us with written notice otherwise.

Name ______________________________

Address ______________________________

Telephone ______________ Relationship ______________

Name ______________________________

Address ______________________________

Telephone ______________ Relationship ______________

Name ______________________________

Address ______________________________

Telephone ______________ Relationship ______________

Name ______________________________

Address ______________________________

Telephone ______________ Relationship ______________

I agree that protected health information regarding my care and/or treatment may be disclosed to the above named individuals. This authorization will remain in effect until I provide written notice to change it.

Signed ______________________________ **Date** ______________

If this form is being signed by a **Patient's Authorized Representative,** please complete the following:

Representative's name ______________________________

Relationship to patient and reason for signing: ______________________________

OAW-013 mmg 6-25-03