ORTHOPAEDIC ASSOCIATES OF WAUSAU

PRO PHYSICAL THERAPY & HAND CENTER
Performance. Rehabilitation. Orthopaedics.

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.

☐ **I am the only person who is to have access to my medical and billing information.**

Emergency Contact:

Name _____

Address _____

Telephone _____ Relationship _____

☐ Emergency Contact Only ☐ May Disclose Medical and Billing Information ☐ May Disclose Medical Information Only ☐ May Grant Portal Access (includes Medical and Billing)

Other Contacts for Disclosure of Records:

1. Name _____

Address _____

Telephone _____ Relationship _____

☐ Medical and Billing
☐ Medical Only
☐ Portal (included Medical & Billing)

2. Name _____

Address _____

Telephone _____ Relationship _____

☐ Medical and Billing
☐ Medical Only
☐ Portal (included Medical & Billing)

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: _____