KLASINSKI CLINIC

ORTHOPAEDICS
SPORTS MEDICINE

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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: Klasinski Clinic
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 The Klasinski Clinic in writing of the revocation.

_____ _____
Signature of Patient Date