SURGICAL ASSOCIATES
of Neenah, S.C.

SURGICAL ASSOCIATES OF NEENAH, S.C.
100 THEDA CLARK MEDICAL PLAZA
SUITE 100
NEENAH, WI 54956-5217
TELEPHONE: (920) 725-4527
FAX: (920) 729-2378

MAY WE CONTACT YOU AT WORK? (Please circle) **Yes** **No** Work Number: _____

MAY WE LEAVE A MESSAGE ON YOU HOME ANSWERING MACHINE REGARDING TEST RESULTS?
(Please circle) **Yes** **No** Home Number: _____

The following persons may receive and give verbal and written information regarding my medical status/treatment with Surgical Associates of Neenah, S.C. for the purpose of assisting us with coordination of care and assist us in following recommendations of the physicians at this practice. Information that is allowed/authorized for sharing may include; information relating to care, testing results, change in treatment plans, medications and dosage, recommendations for continuing care, treatment, and billing, etc. I understand that I may revoke permission to any or all of the undersigned consents either verbally or in writing.

Below please list anyone *other than yourself* for example, family members, spouse, son, daughter, friend or anyone that will be assisting you with your care that we could give information out to if they were to call us or we were to call them. This includes anyone at your home that might be answering the phone in your absence.

If *NO* information is to be given out to anyone other than you, sign here: _____
Date: _____

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____
Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)

(you may list more people on the back)

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)

(you may list more people on the back)

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)

Name: _____ Relationship to you: _____

Addresss: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

_____ _____

Patient Signature/Patient Guardian **Date**

****Authorization to revoke above consent in giving out information on me to this individual****

This consent has been revoked by _____ As witnessed by _____ (Staff name)
