ELMERGREEN ASSOCIATES INC.

114 GRAND AVE

WAUSAU WI 54403

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I consent to the use or disclosure of my protected health information by Elmergreen Associates Inc. For the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Elmergreen Associates Inc.

By signing this form, I give consent to Elmergreen Associates Inc. to use and /or disclose my health information for treatment, payment or health care operations.

_____

Signature of patient or personal representative

_____

Print name of patient or personal representative

_____

Description of personal representative's authority

_____

Date