Plymouth Family Physicians
1000 Eastern Ave.
Plymouth, WI 53073
Phone: 920-893-0526
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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE OR OBTAIN PROTECTED HEALTH INFORMATION TO/ FROM THIRD PARTIES

By signing this authorization, I authorize Plymouth Family Physicians to use, disclose or obtain certain protected health information (PHI) about me to or from the party or parties listed below.

I authorize:(Name and address of Place where records requested from)	**To Release information to**:(Name and address of Place where records will go to)
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

BOXES MUST BE CHECKED OR THIS AUTHORIZATION WILL BE INVALID!

___Physician Notes ___Lab Reports ___Surgical Reports
___Immunization Record ___Pathology Reports ___Other (Specify)____________
___Electrocardiogram ___X-Ray Reports ____________________________
___Eye Records ___X-Ray Films (Specify)________________________________

For the following purpose:

___Changing Physicians ___Payment of Claim ___Personal
___Consultation ___Vocational Rehab Evaluation ___Disability Determination
___Insurance Application ___Legal Investigation ___Other___________________

This authorization will expire on _______________________.
{Expiration Date if no date given will expire one year from date signed}

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Plymouth Family Physicians has acted in reliance upon this authorization. My written revocation must be submitted to Plymouth Family Physicians Privacy Officer at 1000 Eastern Ave., Plymouth WI 53073.

This information ___may be faxed, ___may not be faxed, __may be E-mailed, __may not be E-mailed

______________________________ ______________________________
PRINT Patient's name Patient Date of Birth

______________________________ ______________________________
Patient signature or signature of legal guardian Relationship to patient

____
Today's Date

G:cwword:release3rdparty