Plymouth Family Physicians   1000 Eastern Ave.   Plymouth, WI 53073
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH NFORMATION

With my consent Plymouth Family Physicians may use and disclose my protected health information to carry out treatment, billing and healthcare operations.

Prior to signing this consent I have received and read the Plymouth Family Physicians Notice of Privacy Practices, which is a complete description of such uses and disclosures.

Plymouth Family Physicians reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Plymouth Family Physicians Privacy Officer at 1000 Eastern Ave., Plymouth, WI 53073.

Spouse or significant other's name: ____

With my consent Plymouth Family Physicians may leave messages:
____ on my home answering machine
____ with my spouse; First and last name:_____________________________________
____ with my children or anyone residing at my home
____ with the following person (explain relationship) :____________________________
____ at my work number : _________________________________
____ on my voice mail at the above work number
____ on my cell phone or on its voice mail :(**please leave number)**____________________________
____ on email My email address**: (leave address here)** __________________________

____Plymouth Family Physicians may discuss billing issues with my ____ spouse or ____ parent.

Emergency Contact:______________________________Phone#:____________________________

With my consent, Plymouth Family Physicians may mail to my home or other designated location any items that assist the practice in carrying out treatment, billing and healthcare operations such as appointment reminder cards and patient statements as long as the envelope is marked "Confidential."

I have the right to request that Plymouth Family Physicians restrict how it uses or discloses my protected health information to carry out treatment, billing and healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to Plymouth Family Physicians' use and disclosure of my protected health information to carry out treatment, billing and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures relying on my prior consent.

I have the right to refuse to sign this authorization. If I do not sign this consent, Plymouth Family Physicians may decline to provide treatment. I also have the right to inspect or copy the information to be used or disclosed.

_______________________________________   _____________________________
PRINT YOUR NAME, MAY LIST ALL CHILDREN   SIGNATURE   DATE

PRINT NAME OF LEGAL GUARDIAN IF SIGNING________________________________

PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS CONSENT UPON REQUEST

G: cwword/CONSENT2006