Plymouth Family Physicians   1000 Eastern Avenue   Plymouth WI 53073

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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 any time. A revised "Notice of Privacy Practices" may be obtained by sending a written request to "Plymouth Family Physicians Privacy Offices," 1000 Eastern Avenue, Plymouth, WI 53073

PATIENT NAME:____

DATE OF BIRTH:____

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Plymouth Family Physicians may share this information with the following person(s). The following person(s) will also be considered emergency contacts.

Name: _________________________________ Relationship:_________________________

Home Phone:______________________ Cell:__________________ Work:_________________

Name: _________________________________ Relationship:_________________________

Home Phone:______________________ Cell:__________________ Work:_________________

I consent to receive calls from Plymouth Family Physicians for my protected healthcare and other services at the following phone numbers, including my cell number if provided. I understand I may be charged for such calls by my cell phone carrier and that such calls may be generated by an automated dialing system.

Home Phone:______________________ Cell:__________________ Work:_________________

I have the right to request of Plymouth Family Physicians, restrictions on the use or disclosure of my protected health information, however, Plymouth Family Physicians is not required to agree to my requested restrictions, and if so I will be notified.

I may revoke my consent in writing but this will not affect disclosures made prior to this change.

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.

Signature:____Date:_______________________

Print name of Parent/Legal Guardian if signing for minor:_________________________________

PATIENT/GUARDIAN WILL BE PROVIDED WITH A SIGNED COPY OF THIS CONSENT UPON REQUEST AT TIME OF RECEIPT.