

Patient Authorization for Practice to Release Protected Health Information to Third Parties

I authorize Plymouth Family Physicians, 1000 Eastern Avenue, Plymouth, WI 53073 to release information to: _____

AUTHORIZATION ONLY VALID FOR ITEMS SPECIFICALLY INDICATED:

<input type="checkbox"/>	EKG, Cardiac studies	<input type="checkbox"/>	Lab reports	<input type="checkbox"/>	Radiology reports
<input type="checkbox"/>	Emergency records	<input type="checkbox"/>	Pathology reports	<input type="checkbox"/>	Surgery reports
<input type="checkbox"/>	Eye exams	<input type="checkbox"/>	Physician notes	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Immunization record	<input type="checkbox"/>	Radiology images	<input type="checkbox"/>	

For the following purpose: _____

This information may be: (circle or cross out) FAXED EMAILED MAILED

When my information is used or disclosed pursuant to this authorization it may be subject to re-disclosure 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 [sent to the address for Plymouth Family Physicians listed above] except to the extent that Plymouth Family Physicians has already acted upon the release to prior to the revocation request.

Print patient's name

Patient's date of birth

Signature of patient or legal guardian [Relationship to patient] Date

This authorization will expire one year from the date above.

\\PFPS01\Shared Data Folders\General Shared Data - All domain users have read and write access\HIPPA\RECORD RELEASE FROM PFP