# 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:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | EKG, Cardiac studies | | | Lab reports | | | Radiology reports |
| | Emergency records | | | Pathology reports | | | Surgery reports |
| | Eye exams | | | Physician notes | | | Other: |
| | Immunization record | | | Radiology images | | | |

For the following purpose: _____

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

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.**

\\PFPFS01\Shared Data Folders\General Shared Data - All domain users have read and write access\HIPPA\RECORD RELEASE FROM PFP