Patient Authorization for Practice to Obtain Protected Health Information from Third Parties

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

I authorize: (Name and address of source of requested records)

_____

To release information to:
Plymouth Family Physicians
1000 Eastern Avenue, Plymouth WI 53073
Fax number 920-893-9409 Phone number 920-893-0526

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		

APPROXIMATE DATES OF APPOINTMENTS _____

For the following purpose: CONTINUITY OF PRIMARY CARE

Other: _____

I understand that my medical record and information in connection with the facility stated above may contain reports, records or information about mental health, developmental disabilities, alcohol and/or drug abuse, acquired immune deficiency syndrome (AIDS)/HIV test results and/or information, intoxication tests, and/or fetal monitor tracings.

Test results for the presence of HIV antigen or nonantigenic products of HIV, or an antibody to HIV, may be disclosed without the test subject's consent to persons or under the circumstances specified in Wis. Stat. 252.15 and a list that duplicates the persons or circumstances is available upon request.

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

_____

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.