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: _____

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.