

**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:

<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: CONTINUITY OF PRIMARY CARE
 Other: _____

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

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.