

**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 920-893-9409 Phone 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"/>	Mental health
<input type="checkbox"/>	Immunization record	<input type="checkbox"/>	Radiology images	<input type="checkbox"/>	Substance abuse

APPROXIMATE DATES OF APPOINTMENTS _____

For the following purpose: CONTINUITY OF PRIMARY CARE

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, or an antibody to HIV, may be disclosed without my 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 CD

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.