# 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 my medical records for the purpose of transferring my primary care to:**

_____

_____

_____

**(Please list Clinic and Provider Name, Phone Number)**

**<u>Indicate one of the following:</u>**

I am transferring my care as of 12/31/2021 _____

I am transferring my care immediately _____

**Each record will be provided for pick up at the office on a CD at no cost. Patients will be charged $5 for an additional CD and $15 if mailed.**

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 [Prior last name if applicable] 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.**