

Plymouth Family Physicians  
1000 Eastern Ave.  
Plymouth, WI 53073  
Phone: 920-893-0526  
Fax: 920-893-9409

**PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE OR OBTAIN  
PROTECTED HEALTH INFORMATION TO/ FROM THIRD PARTIES**

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

**I authorize:**(Name and address of  
Place where records requested from)

**To Release information to:**(Name and address of  
Place where records will go to)

_____	_____
_____	_____
_____	_____

**BOXES MUST BE CHECKED OR THIS AUTHORIZATION WILL BE INVALID!**

<input type="checkbox"/> Physician Notes	<input type="checkbox"/> Lab Reports	<input type="checkbox"/> Surgical Reports
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Other (Specify)_____
<input type="checkbox"/> Electrocardiogram	<input type="checkbox"/> X-Ray Reports	_____
<input type="checkbox"/> Eye Records	<input type="checkbox"/> X-Ray Films (Specify)_____	_____

For the following purpose:

<input type="checkbox"/> Changing Physicians	<input type="checkbox"/> Payment of Claim	<input type="checkbox"/> Personal
<input type="checkbox"/> Consultation	<input type="checkbox"/> Vocational Rehab Evaluation	<input type="checkbox"/> Disability Determination
<input type="checkbox"/> Insurance Application	<input type="checkbox"/> Legal Investigation	<input type="checkbox"/> Other_____

This authorization will expire on \_\_\_\_\_.  
{Expiration Date if no date given will expire one year from date signed}

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure 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 except to the extent that Plymouth Family Physicians has acted in reliance upon this authorization. My written revocation must be submitted to Plymouth Family Physicians Privacy Officer at 1000 Eastern Ave., Plymouth WI 53073.

This information \_\_\_may be faxed, \_\_\_may not be faxed, \_\_\_may be E-mailed, \_\_\_may not be E-mailed

\_\_\_\_\_ **PRINT** Patient's name

\_\_\_\_\_ Patient Date of Birth

\_\_\_\_\_ Patient signature or signature of legal guardian

\_\_\_\_\_ Relationship to patient

\_\_\_\_\_ Today's Date

G:cwword:release3rdparty