Planned Parenthood®
Care. No matter what.

Planned Parenthood of Orange and San Bernardino Counties

OR 714.922.4100 | SB 909.890.5511

AUTHORIZATION FORM TO RELEASE OR OBTAIN HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____/_____/_____ SS#: _____-_____-_____ MEDICAL RECORD #: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

*Please fill out **one** of the boxes below:*

TO ALLOW PLANNED PARENTHOOD OF ORANGE AND SAN BERNARDINO COUNTIES TO RELEASE INFORMATION: I authorize Planned Parenthood of Orange and San Bernardino Counties to release information concerning my medical record and/or treatment to:	**TO REQUEST INFORMATION FROM AN OUTSIDE HEALTH CARE PROVIDER:** I authorize the provider named below to release information concerning my medical record and/or treatment to Planned Parenthood of Orange and San Bernardino Counties (send records to the Health Center identified above):
_____ Name	_____ Name
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code
PHONE: _____	PHONE: _____
FAX: _____	FAX: _____

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information: DATES:

- ☐ Entire Medical Record, OR (check the appropriate box(s)) _____
- ☐ History and physical exam _____
- ☐ Substance abuse (including alcohol/drug abuse) _____
- ☐ Lab reports / Radiology reports _____
- ☐ Mental health (including psychotherapy notes) _____
- ☐ HIV related information (AIDS related testing) _____
- ☐ Other: _____ _____

CONDITIONS OF AUTHORIZATION:

1. This Authorization will become effectively immediately upon receipt and shall remain in effect for one year from the date of signature.
2. I may revoke this Authorization at any time by notifying Planned Parenthood of Orange and San Bernardino Counties in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Orange and San Bernardino Counties has already acted upon such Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
4. By authorizing this release of information, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form.
5. I have been offered a copy of this signed Authorization form.
6. I have been informed that Planned Parenthood of Orange and San Bernardino Counties ☐ will/ ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

X_____ OR _____
Patient Signature Date Parent/Legal Guardian/Authorized Person Date

FOR OFFICE USE ONLY

DATE REQUESTED FILLED: _____ BY: _____

ID PRESENTED: _____ FORM OF ID: _____