Planned Parenthood®
of Northeast Ohio

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____
Last First MI Maiden or Other Name

Date of Birth: _____-_____-_____ Ss#: _____-____-_____
Mo Day Yr

Address: _____ City: _____State: _____Zip: _____

I Hereby Authorize Planned Parenthood Of Northeast Ohio To (OBTAIN/RELEASE) My Health Information (TO/FROM):

Name: _____

Address: _____ City: _____State: ____Zip: _____

Phone: _____ Fax: _____

Health Information To Be Obtained / Released:

I Specifically Authorize Release Of The Following Information:

	Dates:		Dates:
❑ Entire Medical Record, Or (Check The Appropriate Box(s)	_____	❑ Lab Reports	_____
❑ History And Physical Exam	_____	❑ Breast Evaluation	_____
❑ Colposcopy/biopsy/LEEP/Cryotherapy	_____	❑ X-Ray Reports/ Ultrasound	_____
❑ HIV Related Information (Aids Related Testing	_____	❑ Progress Notes	_____
❑ Other: _____	_____		

This Authorization Is Made For The Following Purpose:

❑ At My Request, **Or**

❑ Specify: _____

Conditions of Authorization

1. This Authorization Will Expire On (Insert Date Or Event): _____
2. I May Revoke This Authorization At Any Time By Notifying PPNEO In Writing, And It Will Be Effective On The Date Notified Except To The Extent That PPNEO 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.

_____ _____ Or _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ _____
Signature of Witness Date

For Office Use Only

Date Request Processed: _____ By: _____
Identification Presented: _____ Form of identification: _____

Insert Health Center Address

Include Fax and Phone numbers