

PLANNED PARENTHOOD OF GREATER NORTHERN NEW JERSEY

AUTHORIZATION FORM TO RELEASE OR OBTAIN HEALTH INFORMATION

<input type="checkbox"/> 196 Speedwell Ave. (1 st Floor) Morristown, NJ 07960 (973) 539-1364 Fax (973) 539-0055	<input type="checkbox"/> 30 N. Morris Street Dover, NJ 07801 (973) 361-6006 Fax (973) 361-5921	<input type="checkbox"/> 575 Main Street Hackensack, NJ 07601 (201) 489-1140 Fax (201) 489-8077	<input type="checkbox"/> 8 Moran Street Newton, NJ 07860 (973) 383-5218 Fax (973) 383-2060
<input type="checkbox"/> 46 North Van Brunt St. Englewood, NJ 07631 (201) 894-0966 Fax (201) 568-4986	<input type="checkbox"/> Countryside Plaza, 349 Route 31 South Building B, Unit 503 Flemington, NJ 08822 (908) 782-7727 Fax (908) 806-8729	<input type="checkbox"/> 1150 Dickinson Street Elizabeth, NJ 07201 (908) 351-5384 Fax (908) 353-6822	<input type="checkbox"/> 402 Coventry Drive Phillipsburg, NJ 08865 (908) 454-3000 Fax (908) 454-5947
<input type="checkbox"/> 203 S. Main Street Manville, NJ 08835 (908) 231-9230 Fax (908) 231-1565	<input type="checkbox"/> 123 Park Avenue Plainfield, NJ 07060 (908) 756-3736 Fax (908) 156-9272	<input type="checkbox"/> Quality Improvement Coordinator 196 Speedwell Ave. (2 nd Floor) Morristown, NJ 07960 (973) 539-9580 ext. 158 Fax (973) 539-3828	

PATIENT NAME:

_____ LAST _____ FIRST _____ MI _____ MAIDEN OR OTHER NAME _____

DATE OF BIRTH: ____/____/____ SS#: ____-____-____ PATIENT #: _____
MO DAY YR

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

CELL PHONE: _____ BEEPER: _____

<p>TO ALLOW PPGNNJ TO RELEASE INFORMATION: I authorize Planned Parenthood of Greater Northern NJ to release information concerning my medical record and/or treatment to:</p> <p>_____</p> <p>Name _____</p> <p>Street Address _____</p> <p>City, State and Zip Code _____</p> <p>Phone # _____ - _____ - _____</p> <p>FAX# _____ - _____ - _____</p>	<p>TO REQUEST INFORMATION FROM AN OUTSIDE HEALTH CARE PROVIDER: I authorize the health care provider named below to release information concerning my medical record and/or treatment to the Center checked above:</p> <p>_____</p> <p>Name _____</p> <p>Street Address _____</p> <p>City, State and Zip Code _____</p> <p>Phone # _____ - _____ - _____</p> <p>FAX# _____ - _____ - _____</p>
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HEALTH INFORMATION TO BE RELEASED: (Check One): _____ Mail or _____ Will Pick-up

I specifically authorize release of the following information:

- Summary
- Entire Medical Record, OR (check the appropriate box(s))
- History and physical exam
- Progress notes

DATES:

- Substance abuse (including alcohol/drug abuse) _____
- Lab reports _____
- X-ray reports _____
- HIV related information (AIDS related testing) _____
- 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 Planned Parenthood of Greater Northern New Jersey in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Greater Northern New Jersey 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.
5. I have been offered a copy of this signed authorization form.
6. I have been informed that Planned Parenthood of Greater Northern New Jersey will/ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

SIGNATURE OF PATIENT DATE

Signature of Interpreter: _____

Printed Name of Interpreter: _____

COMPLETE IF PATIENT'S GUARDIAN OR RELATIVE IS LEGALLY REQUIRED TO SIGN BELOW
Signature of any other person consenting: _____ Date: _____
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Authorized Person
_____ (Describe authority to act for patient)

FOR OFFICE USE ONLY
DATE INFORMATION RELEASED: _____ BY (STAFF NAME/TITLE): _____
FORM OF IDENTIFICATION PRESENTED: _____