

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire 90 days from the date of my signature, unless I have indicated differently: This release will expire on: _____ (date written by patient).
2. I may revoke this Authorization at any time by notifying Planned Parenthood League of Massachusetts in writing, and it will be effective on the date notified except to the extent that Planned Parenthood League of Massachusetts 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 League of Massachusetts will / will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. **Requests take 10-15 business days to process.**

Signature: _____

Date: _____

or

Parent / Legal Guardian / Authorized Person: _____

Date: _____