



AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

All requests must be received with payment of \$10.00 or records will not be sent.

(Release to third party, not to patient)

Name: _____
(Last) (First) (MI) (Maiden or other)

Date of Birth: _____ SS# _____ Chart# _____

Address: _____ City: _____ State: _____ Zip: _____

Day phone: _____ Evening phone: _____

I HEREBY AUTHORIZE THE FOLLOWING RELEASE OF MY HEALTH INFORMATION:

RECORDS REQUESTED FROM:

SEND RECORDS TO:

Clinic/Provider

Clinic/Provider

Address

Address

City State Zip

City State Zip

Phone # Fax #

Phone # Fax #

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information:

- Entire Medical Record,
- Exclude HIV related information (Aids related testing) only,

or check the appropriate box(s)

- Abortion Procedure/Information Session records and related lab reports only
- Records from most recent visit and related lab reports only
- Records relating to Pap Smears (including follow-up and treatment)
- HIV related information (AIDS-related testing) only
- STD Test results only
- Radiology reports (e.g. ultrasounds) only
- Lab reports only

DATES: _____

Other: _____

This Authorization is made for the following purpose: At my request or Specify _____

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: _____