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|---------------------------------------|---|-------------------------------|
| <input type="checkbox"/> Annapolis | 929 West St., Annapolis, MD 21401 | 410-263-2100 Fax 410-267-9147 |
| <input type="checkbox"/> Baltimore | 330 N. Howard Street, Baltimore, MD 21201 | 410-576-1414 Fax 410-783-2647 |
| <input type="checkbox"/> Easton | 8579 Commerce Drive #102, Easton, MD 21601 | 410-820-9067 Fax 410-820-9674 |
| <input type="checkbox"/> Frederick | 170 Thomas Johnson Dr, #100 Frederick, MD 21702 | 301-662-7171 Fax 301-620-9442 |
| <input type="checkbox"/> Owings Mills | 9129 Reisterstown Rd., Owings Mills, MD 21117 | 410-363-1655 Fax 410-581-9105 |
| <input type="checkbox"/> Salisbury | 1506 S. Salisbury Blvd., Salisbury, MD 21801 | 410-860-4788 Fax 410-860-2549 |
| <input type="checkbox"/> Towson | 1714 Joan Avenue, Baltimore, MD 21234 | 410-665-9775 Fax 410-665-6524 |
| <input type="checkbox"/> Waldorf | 3975 St. Charles Pkwy, Waldorf, MD 20602 | 301-645-6800 Fax 301-645-8696 |

AUTHORIZATION FORM TO RELEASE OR OBTAIN HEALTH INFORMATION

CLIENT 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:*

<p>TO ALLOW PLANNED PARENTHOOD OF MARYLAND TO RELEASE INFORMATION: I authorize Planned Parenthood of Maryland to release information concerning my medical record and/or treatment to:</p> <p>_____</p> <p>Name _____</p> <p>Street Address _____</p> <p>City, State, Zip Code _____</p> <p>PHONE: _____</p> <p>FAX: _____</p>	<p>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 Maryland (send records to the Health Center identified above):</p> <p>_____</p> <p>Name _____</p> <p>Street Address _____</p> <p>City, State, Zip Code _____</p> <p>PHONE: _____</p> <p>FAX: _____</p>
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HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information:

DATES:

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

CONDITIONS OF AUTHORIZATION:

- This Authorization will expire on (insert date or event): _____
- I may revoke this Authorization at any time by notifying Planned Parenthood of Maryland in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Maryland has already acted upon such Authorization.
- 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.
- 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.
- I have been offered a copy of this signed Authorization form.
- I have been informed that Planned Parenthood of Maryland will/ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

X _____ OR _____
 Client Signature Date Parent/Legal Guardian/Authorized Person Date

FOR OFFICE USE ONLY	
Date Request Filled: _____	By: _____
Form of Identification Presented: _____	