

Authorization Form for Release of Information

Patient Name: _____ Patient #: _____
LAST FIRST MI MAIDEN/OTHER NAME

Birthdate: _____ Day Phone: _____ Evening Phone: _____
MO/DAY/YEAR PP OK? Y or N PP OK? Y or N

I HEREBY AUTHORIZE TO RELEASE MY HEALTH INFORMATION

FROM:
 Name: _____
(Person or Clinic)
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____

TO:
 Name: _____
(Person or Clinic)
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____

Health Information to be Released

I specifically authorize release of the following information:

- | | |
|--|---|
| <input type="checkbox"/> Entire Medical Record <i>OR</i> (check appropriate boxes)

<input type="checkbox"/> Medical History
<input type="checkbox"/> Record of Physical Exam
<input type="checkbox"/> Lab Results (non-HIV)
<input type="checkbox"/> HIV Results
<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Other: _____ | Dates:

_____ |
| <input type="checkbox"/> Reason for Release of Information _____ | |

Conditions of Authorization

1. This Authorization will expire on: _____
2. I may revoke this Authorization at any time by notifying Planned Parenthood of Minnesota, North Dakota, South Dakota (PPMNS) in writing, and it will be effective on the date notified except to the extent that PPMNS 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 Federal privacy regulations.
4. Planned Parenthood will not penalize me if I do not sign this authorization.
5. I have been offered a copy of this signed Authorization form.

 Patient Signature Date
 (or legally appointed representative)

 Employee Signature Date

PT. IDENTITY CONFIRMED BY (picture I.D./Signature/SS#): _____