PATIENT AUTHORIZATION TO USE OR RELEASE HEALTH INFORMATION

____
PATIENT/ LAST / FIRST NAME MI PATIENT ID #

____
ADDRESS CITY STATE ZIP CODE

____
DATE OF BIRTH (MM/DD/YYYY)

(________)________________________
DAY PHONE NUMBER

I specifically authorize release of the following information: DATES:

- ❑ Entire Medical Record ____________________
- ❑ History and physical exam ____________________
- ❑ Progress notes ____________________
- ❑ Lab results ____________________
- ❑ X-ray reports ____________________
- ❑ HIV related information ____________________
- ❑ Other: ________________________________ ____________________

TO / FROM: (Circle One)

❑ **Glendale**
5771 W Eugie
Glendale AZ 85304
(602) 277-7526
Fax: (623) 937-3014

❑ **Northeast Phoenix**
3131 E Thunderbird #48
Phoenix AZ 85032
(602) 277-7526
Fax: (602) 953-8052

❑ **Flagstaff**
1304 S Plaza Way
Flagstaff AZ 86001
(928) 779-3653
Fax: (928) 774-5366

❑ **Yavapai**
7750 E. Florentine Rd
Prescott Valley AZ 86314
(928) 776-0420
Fax: (928) 776-4145

❑ **Tempe**
1250 E Apache #108
Tempe AZ 85281
(602) 277-7526
Fax: (480) 921-8712

❑ **Hoffman Center**
529 W Wetmore Rd
Tucson AZ 85705
(520) 884-5562
Fax: (520) 628-3083

❑ **Chandler**
610 N Alma School Rd
Chandler AZ 85224
(602) 277-7526
Fax: (480) 814-1095

❑ **Maryvale**
4616 N 51st Ave #210
Phoenix AZ 85031
(602) 277-7526
Fax: (623) 209-9843

❑ **Scottsdale**
7901 E Thomas #106
Scottsdale AZ 85251
(602) 277-7526
Fax: (480) 429-2326

❑ **Yuma**
1455 W 16th St #C
Yuma AZ 85364
(602) 277-7526
Fax: (928) 343-4845

❑ **Sanger Center**
2255 N Wyatt Dr
Tucson AZ 85712
(520) 884-5562
Fax: (520) 628-3069

❑ **Southeast Mesa**
1235 S Gilbert #20
Mesa AZ 85204
(602) 277-7526
Fax: (480) 892-0403

❑ **Southwest Valley**
140 N Litchfield Rd
Goodyear AZ 85323
(602) 277-7526
Fax: (623) 932-4558

TO / FROM: (Other than self)

____
NAME

____
ADDRESS CITY STATE ZIP CODE

(________)________________________ (________)________________________
PHONE NUMBER FAX NUMBER

Planned Parenthood
Arizona

PATIENT AUTHORIZATION TO USE OR RELEASE HEALTH INFORMATION

1. This Authorization will expire on (insert date or event): ______________________________________
2. I may revoke this Authorization at any time by notifying Planned Parenthood Arizona in writing, and it will be effective on the date notified except to the extent that Planned Parenthood Arizona 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. There is a $40.00 retrieval fee and a copy fee for all records requested that have been inactive for more than 15 months and have been purged. Paid for prior to submitting the request for retrieval.
6. I have been offered a copy of this signed Authorization form.
7. I have been informed that Planned Parenthood Arizona ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

If you are requesting PPAZ to release A COPY OF YOUR MEDICAL RECORDS to you, for your own personal use please check this box. ☐

Mailing address if requesting PPAZ to mail you a copy of your medical records:

____
ADDRESS CITY STATE ZIP CODE

____

PATIENT SIGNATURE: ________________________________

DATE: _______________

OR

PARENT/LEGAL GUARDIAN SIGNATURE: ___________________________

DATE: _________________

FOR OFFICE USE ONLY

FORM OF IDENTIFICATION PRESENTED: ____

DATE COMPLETED: _______________ BY: ___________________________________