

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: - - SS#: - - MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF EAST CENTRAL IOWA TO RELEASE MY HEALTH INFORMATION TO:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

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"/> Progress notes | _____ |
| <input type="checkbox"/> Substance abuse (including alcohol/drug abuse) | _____ |
| <input type="checkbox"/> Lab reports | _____ |
| <input type="checkbox"/> Mental health (including psychotherapy notes) | _____ |
| <input type="checkbox"/> X-ray reports | _____ |
| <input type="checkbox"/> HIV related information (AIDS related testing) | _____ |
| <input type="checkbox"/> Other: _____ | _____ |

This Authorization is made for the following purpose:

- At my request, OR
 Specify: _____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on (insert date or event): _____

2. I may revoke this Authorization at any time by notifying PP of East Central Iowa in writing, and it will be effective on the date notified except to the extent that PP of East Central Iowa 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.

SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

FOR OFFICE USE ONLY	
DATE REQUEST FILLED: _____	BY: _____
IDENTIFICATION PRESENTED: _____	FORM OF IDENTIFICATION: _____