

PLANNED PARENTHOOD GOLDEN GATE

**EASTMONT, HAYWARD, MACARTHUR, REDWOOD CITY, ROHNERT PARK,
SAN FRANCISCO, SAN MATEO & SAN RAFAEL**

To get information or to make an appointment at any of the above health centers please call:
1-800-967-PLAN (7526)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Client Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE AND REQUEST (FOR A FEE OF \$5.00):

Name: _____

Address: _____

Phone: _____ Fax: _____

TO RELEASE MY HEALTH INFORMATION AND SEND IT TO:

Name: _____

Address: _____

Phone: _____ Fax: _____

**I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING
INFORMATION:**

- _____ My complete medical records
- _____ My records for the time period of _____ to _____.
- _____ Birth control visits only
- _____ Pregnancy related visits only
- _____ Lab test results (Pap smear, blood tests, STD tests) only
- _____ Other: _____

CONDITIONS OF AUTHORIZATION

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

2. I may revoke this Authorization at any time by notifying Planned Parenthood Golden Gate in writing, and it will be effective on the date notified except to the extent that Planned Parenthood Golden Gate 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.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

FOR OFFICE USE ONLY:

INFORMATION SENT: _____

BY _____

\$5.00 PAYMENT RECEIVED: _____