

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

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF LOUISIANA AND THE MISSISSIPPI DELTA (PPLAMD) TO RELEASE MY HEALTH INFORMATION TO (see name and address below): OR

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF LOUISIANA AND THE MISSISSIPPI DELTA (PPLAMD) TO RELEASE MY HEALTH INFORMATION TO THE APPROPRIATE LAW ENFORCEMENT AGENCY/AGENCIES INVESTIGATING THE INCIDENT REPORTED TO PPLAMD ON _____ (date of report).

NAME: _____
Name of person, facility or agency to whom the information should be sent

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

PHONE: _____ FAX: _____

I HEREBY AUTHORIZE _____
(NAME AND ADDRESS OF DOCTOR OR CLINIC)

Doctor's PHONE: _____ Doctor's FAX: _____

TO RELEASE MY HEALTH INFORMATION TO THE PLANNED PARENTHOOD CLINIC LISTED BELOW (check one):

<input type="checkbox"/> Magazine Street Health Center 4018 Magazine Street New Orleans, LA 70115 Phone: (504) 897-9200 Fax: (504) 897-9234	<input type="checkbox"/> Baton Rouge Health Center 3955 Government Street, Suite 2 Baton Rouge, LA 70806 Phone: (225) 387-1167 Fax: (225) 344-7215
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Please send the information to the address and to the attention of the person named on the attached business card.

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information:

- Entire Medical Record, OR [check the appropriate box(s)]:
- History and physical exam
 - Progress notes
 - Lab reports
 - Mental health (including psychotherapy notes)
 - X-ray/ultrasound reports
 - HIV related information (AIDS related testing)
 - Other: _____

DATES:

This Authorization is made for the following purpose:

- At my request, OR
- Specify: _____

CONDITIONS OF AUTHORIZATION

- This Authorization will expire on (insert date or event): _____
- I may revoke this Authorization at any time by notifying PPLAMD in writing, and it will be effective on the date notified except to the extent that PPLAMD 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.

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