

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 PP OF THE SOUTHERN FINGER LAKES: TO RELEASE TO OBTAIN

MY HEALTH INFORMATION TO/FROM:

NAME: _____

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

PHONE: _____ FAX: _____

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information:

DATES

- Most recent annual exam _____
- All visits since: (fill in date) → _____
- Pap Smear _____
- Lab reports _____
- Progress notes _____
- Abortion Record _____
- Follow Up Care related to Medical Abortion of _____
- Follow Up Care related to Surgical Abortion of _____
- Other: _____
- Entire Medical Record (Fee of \$.50/page. Please allow 10 days. We cannot refuse to give you a copy due to inability to pay)

PURPOSE OF RELEASE OF INFORMATION: At my request Continuity of care
 Other: _____

To ensure that our records are current and accurate, please complete & return this form promptly to the clinic site checked below. This will enable us to provide our client with proper medical care. Thank you for your cooperation.

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Corning
135 Walnut St.
(607)962-4686
(607)962-7520 fax | <input type="checkbox"/> Elmira
755 E. Church St.
(607)734-3313
(607)734-3392 fax | <input type="checkbox"/> Hornell
174 Main St.
(607)324-1124
(607)324-2666 fax | <input type="checkbox"/> Ithaca
314 W. State St.
(607)273-1513
(607)273-8776 fax | <input type="checkbox"/> Watkins Glen
106 W. 4 th St.
(607)535-0030
(607)535-5040 fax |
|--|--|--|---|---|

CONDITIONS OF AUTHORIZATION

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

WITNESS DATE AUTHORITY TO ACT ON BEHALF OF PATIENT

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