



**MINOR'S AUTHORIZATION FOR PLANNED PARENTHOOD OF ----
TO NOTIFY HER PARENT OR LEGAL GUARDIAN & AUTHORIZATION TO RELEASE
HEALTH INFORMATION**

Because I am less than 18 years of age and plan to terminate a pregnancy, I understand that Planned Parenthood of Southwest & Central Florida will notify one of my parents or my legal guardian in accordance with state law.

I, _____, give consent to PPSWCF to contact by telephone and/or by certified mail the parent(s) or legal guardian named below to inform her/him of my intention to terminate my pregnancy. I further waive any legal claim that I may have against PPSWCF, any of its physicians, employees or agents that may arise as a result of this notification.

In order to give us flexibility, you may name more than one parent, but we will contact only one. Do not provide any phone number we should not use to attempt to contact your parents/guardian. All phone numbers written on this form may be used to contact your parent or guardian.

Name of Parent or Legal Guardian _____

Address of Parent or Legal Guardian _____

Telephone number where Parent(s) or Legal Guardian may be reached

Home _____
Work _____
Cell _____

Best time to call: _____

I understand that in order to provide notice to the above designated parent(s) or legal guardian Planned Parenthood will have to disclose certain health information relating to my termination. Therefore, I hereby authorize Planned Parenthood to release the following health information:

1. The name and address of the facility providing the termination of pregnancy;
2. The name of the physician providing notice;
3. General (non-patient specific) information regarding abortion and abortion procedures.

I understand no other information shall be provided to the above designated parent(s) or legal guardian without my further authorization.

I hereby state that the person and or persons I have selected to receive notification is either my parent or legal guardian, as I indicated.

I further state that to the best of my knowledge, information or belief that the above is true, accurate and correct:

Patient's Signature: _____

Date: _____

FOR STAFF USE ONLY

Date and Time of appointment: _____

Notice must be given by: _____