Planned Parenthood
Shasta-Diablo®

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: ____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____
MO DAY YR

ADDRESS: ____

CITY: ______________________ STATE: ________ ZIP: ____________

DAY PHONE: ______________________ EVENING PHONE: ______________________

I HEREBY AUTHORIZE PLANNED PARENTHOOD: SHASTA-DIABLO **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:
❑ Entire Medical Record, OR (check the appropriate box(s))	____________
❑ History and physical exam	____________
❑ Progress notes	____________
❑ Substance abuse (including alcohol/drug abuse)	____________
❑ Lab reports	____________
❑ Mental health (including psychotherapy notes)	____________
❑ X-ray reports	____________
❑ HIV related information (AIDS related testing)	____________
❑ Other: ______________________	____________

This Authorization is made for the following purpose:

❑ At my request, OR

❑ Specify: ____

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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: Shasta-Diablo in writing, and it will be effective on the date notified except to the extent that Planned Parenthood: Shasta-Diablo 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.

6. **[If this authorization is for Marketing, add the following:]** I have been informed that Planned Parenthood: Shasta-Diablo ❑ **will**/ ❑ **will not** receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

______________________________ ______________ OR
SIGNATURE OF PATIENT DATE

______________________________ ______________
PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

FOR OFFICE USE ONLY

DATE REQUEST FILLED: ______________________________

BY: ______________________________

IDENTIFICATION PRESENTED: ______________________________

FORM OF IDENTIFICATION: ______________________________