



SIX RIVERS PLANNED PARENTHOOD®  
PO Box 1416 Weaverville, CA 96093

Phone: (530) 623-4310  
FAX: (530) 623-4386

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

Patient Name (please print) : \_\_\_\_\_  
Last First MI Maiden or Other Name

Date Of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS#: (Optional) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Medical Record #: \_\_\_\_\_  
MO DAY YR

Phone: \_\_\_\_\_ PP OK? \_\_\_\_\_

**I AUTHORIZE SIX RIVERS PLANNED PARENTHOOD:  TO RELEASE  TO OBTAIN**

**MY HEALTH INFORMATION TO/FROM:**

Name of Individual or Agency \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Please release the following:** (Provide dates if requesting specific information)

- Most recent annual exam (including breast exam, pap, pelvic, progress notes)
- Most recent Pap smear & STD screening test results
- Last birth control method used
- All abortion related services
- Other \_\_\_\_\_

**For the purpose of:**  Continuing Care  Other (Be specific): \_\_\_\_\_

**CONDITIONS OF AUTHORIZATION**

1. This Authorization will expire  **in one year OR** (insert date/event): \_\_\_\_\_
2. I may revoke this Authorization at any time by notifying Six Rivers Planned Parenthood in writing, and it will be effective on the date notified except to the extent that Six Rivers Planned Parenthood has already acted upon such Authorization.
3. Information used or disclosed as a result of this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. Not everyone is subject to HIPAA guidelines.
4. By authorizing this release of information, my healthcare and payment for my healthcare will not be affected.
5. I have been offered a copy of this signed Authorization form.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Signature Verified by \_\_\_\_\_ (Staff Initials) **OR**  Identification Presented (Form of Identification) \_\_\_\_\_

**(STAFF) Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**FOR SRPP OFFICE USE ONLY**

Records sent for \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_ 2nd Request \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_

Records Faxed \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_ Records Re-Faxed \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_

Patient to Pick up on: \_\_\_\_\_ Handcarried \_\_\_\_/\_\_\_\_/\_\_\_\_ By \_\_\_\_\_