AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

WHAT OTHER NAMES HAVE YOU USED: _____

DATE OF BIRTH: _____-_____-_____ (MO DAY YR) SS#: _____-_____-_____ MEDICAL RECORD #: _____

❑ I HEREBY AUTHORIZE PLANNED PARENTHOOD GULF COAST, INC (PPGC) TO RELEASE MY HEALTH INFORMATION TO (see name and address below); OR

❑ I HEREBY AUTHORIZE PLANNED PARENTHOOD (PPGC) TO RELEASE MY HEALTH INFORMATION TO THE APPROPRIATE LAW ENFORCEMENT AGENCY/AGENCIES INVESTIGATING THE INCIDENT REPORTED TO PPGC 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 HEALTH CENTER LISTED BELOW (check one)
Please send the information to the Health Center below and to the ATTENTION of _____.

❑ Dickinson - 3315 Gulf Frwy, Dickinson, TX 77539	Ph.# 713-514-1105	Fx.# 404-494-7435
❑ Greenspoint - 11834 Airline Drive, Houston, TX 77037	Ph.# 713-514-1103	Fx.# 404-494-7435
❑ Northwest – 13169 Northwest Freeway, Suite 115, Houston, TX 77040	Ph.# 713-514-1107	Fx.# 404-494-7435
❑ Prevention Park Dysplasia Clinic - 4600 Gulf Freeway, Houston, TX 77023	Ph.# 713-522-3976	Fx.# 404-494-7433
❑ Prevention Park Family Planning – 4600 Gulf Freeway, Houston, TX 77023	Ph.# 713-522-3976	Fx.# 404-494-7435
❑ Southwest – 5800 Bellaire Blvd, Suite 120, Houston, TX 77081	Ph.# 713-541-5372	Fx.# 404-494-7435
❑ Spring – 4747 Louetta Rd, Spring, TX 77388	Ph.# 713-514-1102	Fx.# 404-494-7435
❑ Stafford – 12614 Southwest Fwy., Suite A, Stafford, TX 77477	Ph.# 713-514-1100	Fx.# 404-494-7435

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 _____
- ❑ Lab reports _____
- ❑ Mental health (including psychotherapy notes) _____
- ❑ X-ray/ultrasound reports _____
- ❑ HIV related information (AIDS related testing) _____
- ❑ Other: _____ _____

This Authorization is made for the following purpose:
❑ At my request, *OR* ❑ Specify: _____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on one year from the date below.
2. I may revoke this Authorization at any time by notifying PPGC in writing, and it will be effective on the date notified except to the extent that PPGC 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 I have been informed that PPGC ❑ 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