Planned Parenthood®
Care. No matter what.
Planned Parenthood Hudson Peconic

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Affix Client Label

CLIENT 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 PLANNED PARENTHOOD HUDON PECONIC 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 _____
- ❑ Sonogram reports _____
- ❑ HIV related information (AIDS related testing) _____
- ❑ Other: _____ _____

This Authorization is made for the following purpose:

- ❑ At my request, OR
- ❑ Specify: _____

Affix Client Label

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 Hudson Peconic, Inc. in writing, and it will be effective on the date notified except to the extent that Planned Parenthood Hudson Peconic, Inc. 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.

For Authorization for Marketing Only:

6. I have been informed that Planned Parenthood Hudson Peconic, Inc. ❑ will / ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

_____ _____
Signature of Client Date

OR

_____ _____
Parent / Legal Guardian / Authorized Person Date

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____

FORM OF IDENTIFICATION: _____