

**AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION TO PLANNED PARENTHOOD**

Name:

 *(Last)* *(First)* *(Middle Initial)*

Date of Birth:

Address: City: State: Zip:

Day Phone:

**I HEREBY AUTHORIZE THE FOLLOWING RELEASE OF MY PROTECTED HEALTH INFORMATION:**

**RECORDS REQUESTED FROM: SEND RECORDS TO:**

Planned Parenthood League of Massachusetts

*Clinic/Provider Clinic/Provider*

1055 Commonwealth Avenue

*Address Address*

Boston MA 02215

*City State Zip City State Zip*

(617) 616-1600 (413) 726 1264

*Phone Number Fax Number Phone Number Fax Number*

**HEALTH INFORMATION TO BE RELEASED:**

I hereby specifically authorize release of the following information for treatment dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Abortion Procedure records and related lab reports
* Records related to Pap Smears (including follow-up and treatment)
* Sexually Transmitted Diseases test results
* HIV-related information (AIDS-related testing)
* Radiology Reports (i.e. ultrasounds)
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONDITIONS OF AUTHORIZATION**

1. This Authorization will expire 90 days from the date of my signature, unless I have indicated differently:

This release will expire on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date written by patient).

2. I may revoke this Authorization at any time by notifying Planned Parenthood League of Massachusetts in writing, and it will be effective on the date notified except to the extent that Planned Parenthood League of Massachusetts 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.

*Signature of Patient Date*

**or**

*Parent/Legal Guardian/Authorized Person Date*