 **Mailing Address:**

Planned Parenthood League of Massachusetts

Medical Records Department

1055 Commonwealth Avenue

Boston, MA 02215

Phone: 617-616-1600  
Fax: 844-791-0108

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

Name:

*(Last)* *(First)* *(Middle Initial)* *(Maiden or other)*

Date of Birth: Medical Record Number *(if known)*:

Address: City: State: Zip:

Day Phone: Alternative Phone:

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

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

**Planned Parenthood League of Massachusetts**

**Medical Records Department**

*Clinic/Provider Clinic/Provider*

**1055 Commonwealth Avenue**

*Address Address*

**Boston MA 02215**

*City State Zip City State Zip*

**617-616-1600 844-791-0108**

*Phone Number Fax Number Phone Number Fax Number*

**HEALTH INFORMATION TO BE RELEASED:**

This authorization is made for the following purpose:

* At my personal request, OR Specify:  Insurance  Medical Care  Legal Matter  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

* Records from most recent visit and related lab reports
* 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)
* Lab result information
* 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*