**AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION**

PATIENT NAME: \_\_\_\_\_\_\_\_

 LAST FIRST MI OTHER

DATE OF BIRTH: \_\_\_\_-\_\_\_\_-\_\_\_\_ BEST PHONE NUMBER (TYPE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_ CITY: STATE:\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_

**I hereby authorize Planned Parenthood of the North Country New York (PPNCNY) to obtain my health information from: “Any health plan, physician, health care provider that has provided payment, treatment, or services to me or on my behalf” HHS 45 CFR 164.508 (c) (1) (ii)**

 **I specifically authorize release of the following information for the following date range: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5** Last annual visit summary **5** Blood work reports **5** HIV-Related Information

* Last PAP report **5** Biopsy report **5** Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5** Mammogram report **5** Alcohol/Drug Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* X-ray report/Ultrasound report **5** Mental Health Information
* Entire Medical Record

**Name & Address of Health Provider to whom information will be sent:**

**Name & Address of Health Provider to release above consented information to PPNCNY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Conditions of Authorization**

1. This Authorization will expire on (insert date or event):
2. I may revoke this Authorization at any time by notifying PPNCNY in writing, and it will be effective on the date notified except to the extent that PPNCNY has already acted upon such request.
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
5. I have been offered a copy of this signed Authorization Form.

\_\_\_\_\_\_\_\_ \_ OR \_\_\_\_\_\_\_\_\_

Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

**Return Health Information To:**

 **Planned Parenthood of the North Country New York**

**66 Brinkerhoff St. Plattsburgh, NY 12901**

 **P: (518) 561-4430 / F: (518) 536-9046**

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|  **FOR OFFICE USE ONLY** Date Request Filled; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider requesting PHI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Form of Identification presented: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |