Planned Parenthood®
Care. No matter what.
Planned Parenthood of Western Pennsylvania

Authorization Form for Release of Health Information

Patient name (First, last, MI, Maiden or Other)			*Medical Record#*
Address	*City*	*State*	*Zip*
Date of birth	*Day phone*	*Alt. phone*	

I hereby authorize:

Name of location to release records from			
Address	*City*	*State*	*Zip*
Phone	*Fax*		

To release information to:

Name of location to release records to			
Address	*City*	*State*	*Zip*
Phone	*Fax*		

I specifically authorize the release of the following information

☐ **Entire medical record (Includes Behavioral Health Documents)**
OR

	Dates:
☐ History and physical exams	
☐ Progress notes	
☐ Substance abuse (including alcohol/drug abuse)	
☐ Lab reports	
☐ Radiology reports	
☐ HIV related information (AIDS related testing)	
☐ Other: _____	

Behavioral Health Documents	Dates:
☐ Dates of Attendance (Least detailed information)	
☐ Discharge Summary	
☐ Intake (History)	
☐ Treatment Plan	
☐ Progress Notes (Most detailed information)	

This authorization is made for the following purpose: ☐ **At my request** ☐ **Specify:** _____

1. This authorization expires (date or event): **upon completion**
2. I may revoke this authorization at any time by notifying Planned Parenthood of Western Pennsylvania in writing, and it will be effective on the date notified except to the extent the PPWP 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*

(if needed) Parent/Legal Guardian/Authorized Person *Date*