Planned Parenthood®
Planned Parenthood of the Heartland

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME: _____
Last First MI

DATE OF BIRTH: _____ SS#: _____/_____/_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DAY PHONE: _____ EVENING PHONE: _____

***I HEREBY AUTHORIZE:*** _____
*(name)* *(phone)* *(fax)*

_____
*(address)*

***TO RELEASE MY HEALTH INFORMATION TO:***

NAME: _____ Phone: _____ Fax: _____

ADDRESS: _____

***HEALTH INFORMATION TO BE RELEASED:***

| ***I specifically authorize release of the following information:*** | ***DATES:*** |
|---|---|
| Check the appropriate box(s): | |
| □ History and physical exam | |
| □ Progress notes | |
| □ Substance abuse (including alcohol/drug abuse) | |
| □ Lab reports | |
| □ Mental health (including psychotherapy notes) | |
| □ X-ray reports | |
| □ HIV related information (AIDS related testing) | |
| □ Other: _____ | |
| □ Entire Medical Record | |

***This Authorization is made for the following purpose***:
□ At my request, OR
□ Specify:_____

***CONDITIONS OF AUTHORIZATION***

1. This Authorization will expire in one year or as specified otherwise by the Individual:
   _____
2. I may revoke this Authorization at any time by notifying Planned Parenthood of the Heartland in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of the Heartland 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.

_____ _____ **OR** _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

**STAFF USE ONLY**
By:_____ Form of Identification:_____