

Authorization Form for Release of Health Information to Self

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

I hereby authorize:

<i>Name of location to release records from</i> Planned Parenthood of Western Pennsylvania			
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
933 Liberty Ave	Pittsburgh	PA	15222
<i>Phone</i>	<i>Fax</i>		
(412) 434-8971	(412) 434-8975		

To release information to:

<i>Name</i> Self

I specifically authorize the release of the following information

Dates:

- Entire medical record**
- OR
- History and physical exams
- 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: _____

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.

<i>Signature of Patient</i>	<i>Date</i>
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(if needed) Parent/Legal Guardian/Authorized Person

Date