

**AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION**

*Print, fill and fax this Authorization Form to the medical center where you received services last.*

**Select Medical Center:**

 □ **ALLENTOWN**  □ **BENSALEM** □ **HARRISBURG** □ **LANCASTER**

 29 N 9th Street 2185 Galloway Road 1514 N Second Street 31 S Lime Street

 Allentown, PA 18103 Bensalem, PA 19020 Harrisburg, PA 17102 Lancaster, PA 17602

 F: (610) 439-0502 F: (215) 638-1192 F: (717) 901-5351 F:(717) 299-2004

 □ **QUAKERTOWN** □ **READING** □ **STROUDSBURG** □ **YORK**

 401 W Broad Street 48 S Fourth Street 28 n Seventh Street 728 S Beaver Street

 Quakertown, PA 18951 Reading, PA 19610 Stroudsburg, PA 18306 York, PA 17405

 F: (215) 529-5405 F: (610) 378-1698 F: (570) 476-4580 F: (717) 843-2698

 □ **WARMINSTER** □ **WILKES BARRE** □ **Other Center** (not listed) \_\_\_\_\_\_\_\_\_\_\_

 610 Louis Drive 2nd Floor 63 N Franklin Street F:(610) 481-0486

 Warminster, PA 18974 Wilkes Barre, PA

 F: (215) 957-6481 F: (570) 825-0626

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **D.O.B** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Planned Parenthood Keystone to release my health information to:

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_

**HEALTH INFORMATION TO BE RELEASED:**

I specifically authorize release of the following information:

□ Entire Medical Record, OR (check the appropriate boxes) □History and physical exam

□Progress notes □Lab reports □X-ray report □HIV related information (AIDS related testing)

□Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This Authorization is made for the following purpose:

□ At my request, OR

□ Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **CONDITIONS OF AUTHORIZATION:**

1. This Authorization will expire on (insert date or event): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. I may revoke this Authorization at any time by notifying Planned Parenthood Keystone in writing, and it will be effective n the date notified except to the extent that Planned Parenthood Keystone had 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 Rules.
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.
6. I have been informed that Planned Parenthood Keystone □ will/ □ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

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

 Signature of Patient Date

OR

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

 Signature of Parent/Legal Guardian Date

 Authorized Person

**FOR OFFICIAL USE ONLY**

DATE REQUESTED FILLED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IDENTIFICATION PRESENTED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FORM OF IDENTIFICATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_