Authorization: Release of Medical Information

CLINIC ADDRESS LABEL HERE

PATIENT LABEL HERE

PLEASE COMPLETE

Patient name: _____

Date of birth: _____

I, THE UNDERSIGNED, HEREBY AUTHORIZE PPGOH TO:

___Release ___Obtain

INFORMATION CONTAINED IN MY MEDICAL RECORD TO/FROM:

Health provider: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

THE FOLLOWING INFORMATION IS NEEDED FOR CONTINUITY OF CARE:

___Pelvic exam

___Breast exam

___Pap/Pathology results

___Record of last Depo injection

___Colposcopy results

___Colposcopy exam notes/plan of care

___Procedure notes

___Laboratory tests

___Other: _____

This Authorization is made for the following purpose: ___At my request, OR ___Specify:_____

*If releasing records to another provider:

PP location where you were last seen:_____ Year of your last visit at that location:_____

CONDITIONS OF AUTHORIZATION

1. This Authorization is valid for ninety (90) days.
2. I may revoke this Authorization at any time by notifying Planned Parenthood in writing, and it will be effective on the date notified except to the extent that Planned Parenthood 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.

Patient signature: _____ Date:_____

Witness: _____ Date:_____

FOR OFFICE USE ONLY. Date request filled:_____ By:_____

Identification presented:_____ Form of identification:_____