AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Planned Parenthood of Central and Western New York to:

PPCWNY health center address_____
PPCWNY fax_____

☐ send copies of my health records to:
☐ obtain copies of my health records from:
☐ speak to:

Name of provider _____

Address _____

Phone _____ Fax _____

This authorization is made for the following purpose:

☐ at my request **AND/OR** ☐ specify reason _____

Health information to be released/obtained:

◯ ***All*** records regarding my care and treatment ***including*** HIV information
◯ ***All*** records regarding my care and treatment ***excluding*** HIV information

Other: ☐ GYN care
☐ Preventive visit
☐ Pathology/Biopsy _____
☐ Lab Reports _____
☐ Other specific information _____

Conditions of Authorization:

1. This authorization will expire one year from the date of my signature on this form.
2. I understand this authorization is voluntary and may be revoked at any time by notifying Planned Parenthood of Central and Western New York in writing and it will be effective on the date notified except to the extent PPCWNY has already acted upon such authorization.
3. I understand the information 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 health care and payment for my health care will not be affected if I do not sign this Authorization form.
5. I may request a copy of this signed Authorization.

Patient name _____

Date of birth _____

Address _____

Patient signature_____ **Date**_____ **Legal guardian signature**_____ **Date**_____

For office use only

Medical Record Number

Date request filled **Request filled by**