Planned Parenthood® of the Southern Finger Lakes

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Patient Name	Maiden or Other Name	Medical Record Number
Patient Address		
Date of Birth / /	Telephone number ( ) -	Social Security Number - -

I HEREBY AUTHORIZE PP OF THE SOUTHERN FINGER LAKES (specify health center below)

☐Corning	☐Elmira	☐Hornell	☐Ithaca	☐Watkins Glen
135 Walnut St.,14830	755 E. Church St.,14901	PO Box 268	620 W Seneca St., 14850	106 W. 4th St., 14891
(607)962-4686	(607)734-3313	111 Seneca St., 14843	(607)273-1513	(607)535-0030 Ph/Fax
(607)962-7520 fax	(607)734-3392 fax	(607)324-1124	(607)273-8776 fax	
		(607)324-2666 fax		

❑ To Release Copies of my Health Record to:
❑ To Obtain Copies of my Health record from:
❑ To discuss my medical care with:

Name of Provider/Entity:_____

Address: _____

_____

Tel # (____) ____ - _____ Fax # (____) _____ - _____

I specifically authorize release of the following information:

❑ Medical Record from (insert date) _____ to (insert date) _____
❑ Pap Smear: ❑ All or ❑ (insert dates) _____
❑ Lab reports (specify labs) _____
❑ Follow Up Care related to Medical Abortion of (insert date) _____
❑ Follow Up Care related to Surgical Abortion of (insert date) _____
❑ Other: _____
❑ Entire Medical Record

OK to include, if records contain:
(*Indicate by Initialing*):
_____ HIV-related information
_____ Abortion records

PURPOSE OF RELEASE OF INFORMATION: ❑ At my request ❑ Continuity of care ❑ Other: _____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire 1 year from the date of my signature on this form or ____/_____/_____ (whichever comes first)
2. This authorization may include disclosure of CONFIDENTIAL HIV RELATED INFORMATION only if I place my initials on the appropriate line above.
3. If I am authorizing the release of HIV-related information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the NYS Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
4. I may revoke this Authorization at any time by notifying PP of the Southern Finger Lakes in writing, and it will be effective on the date notified except to the extent that PP of the Southern Finger Lakes has already acted upon such Authorization.
5. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient (except as noted above in Item 2) and no longer protected by Federal privacy regulations.
6. 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.
7. I have been offered a copy of this signed Authorization form.

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

_____ _____ _____
WITNESS DATE AUTHORITY TO ACT ON BEHALF OF PATIENT

DATE REQUEST COMPLETED: _____ BY: _____