Planned Parenthood
Care. No matter what.

Planned Parenthood
Pasadena & San Gabriel Valley

AUTHORIZATION AND REQUEST FOR ACCESS TO HEALTH INFORMATION

- Alhambra Health Center | 330 S. Garfield Ave. Suite 300, Alhambra, CA 91801
- Baldwin Park Health Center | 4070 Sterling Way, Baldwin Park, CA 91706
- Glendora Health Center | 130 W. Route 66, Suite 100, Glendora, CA 91740
- Highland Park Health Center | 5903 N. Figueroa St. Highland Park, CA 90042
- Pasadena Health Center | 1045 N. Lake Ave. Pasadena, CA 91104

1	**Patient Name:**	**Patient Date of Birth:**
	Patient Address:	**Patient Phone:**

PATIENT REQUEST

2 I HEREBY REQUEST access to ○ *inspect or* ○ *obtain a copy* (check the box that applies) of my health information held by Planned Parenthood Pasadena and San Gabriel Valley. I request that the information be provided in the following format (select from Box 3 or 4).

3

○ Paper Copy (Select one):

- ○ Self pick up
- ○ Fax to: _____
- ○ Mail ○ To address in Box 1 ○ To address below

Name:	**Address:**

○ Electronic Copy (available only for information maintained electronically).

○ Emailed to you at the following address: _____

IF YOU WISH HEALTH INFORMATION TO BE SENT TO YOU OR SOMEONE ELSE VIA EMAIL, PLEASE READ SECTION 1, "RISKS OF USING EMAIL", IN THE CONDITIONS FOR AUTHORIZATION.

CONTINUATION OF CARE REQUEST

4

○ I HEREBY AUTHORIZE Planned Parenthood Pasadena and San Gabriel Valley to Release my health information to (Provider below)

○ I HEREBY AUTHORIZE (Provider below) to release my health information to Planned Parenthood Pasadena and San Gabriel Valley

- ○ Mail to: Care Team 1037 N Lake Ave Pasadena, CA 91104
- ○ Fax to: (626) 798-2919
- ○ Fax to other: _____

Provider Name:	**Provider Phone:**

	Provider Address:	**Provider Fax:**
5	**HEALTH INFORMATION TO BE RELEASED I specifically authorize release or receipt of the following information for the following date range: *Date/s* _____ *to* _____** ○ All Pap Smear Tests ○ All lab reports (does not include HIV testing) ○ Visit summary (Includes physical exam) ○ Exclude substance abuse notes ○ Exclude mental health notes ○ Patient History (Includes substance abuse and mental health) ○ HIV related information (AIDS related testing) ○ Entire Medical Record (Includes HIV information, substance abuse & mental health) ○ Other: _____ ○ Records from receiving facility to which I may be transferred (For patients being transferred or referred out only)	

CONDITIONS OF AUTHORIZATION

1. **RISKS OF USING E-MAIL to receive your health records: E-mail may not be reliable, secure, or private. For example:**
   - **E-mail can be hacked. (Unauthorized people can intercept it, alter it, or use it).**
   - **E-mail can be sent to the wrong person, lost, or subject to other sending errors.**
   - **E-mail may come from someone other than the named sender.**
   - **E-mail is easier to fake than handwritten, signed papers.**
   - **Anyone with access to an e-mail account will have access to all messages in that account. This includes those who have permission to use the e-mail account as well as those who do not.**
   - **Anyone who gets or has access to an e-mail can read, forward, copy, delete, or change it. This includes those who have permission to use the e-mail account as well as those who do not.**
   - **Any deleted e-mails can be found again.**
   - **E-mail services have a right to save and check e-mail sent through their system.**
   - **E-mail can spread viruses.**
   - **You should not receive your health information via email if people who you don't want to view your medical information have access to your e-mail account.**

2. **THIS REQUEST IS LIMITED BY LAW. Except as provided by California Law, this request for access to inspect or obtain a copy of health information is subject to all of the limitations found at 45 C.F.R. 164.524.**

3. **THIS REQUEST IS FURTHER LIMITED. There is no right to request access to inspect or obtain a copy of: a) Psychotherapy notes; b) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; or c) Information subject to the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. 263a or any exceptions found at 42 C.F.R. 493.3(a)(2)).**

4. **TIME FOR RESPONSE. Planned Parenthood Pasadena and San Gabriel Valley (PPPSGV) has up to five (5) days after receipt of this request to respond to a request for inspection and fifteen (15) days after receipt of this request to act on a request for copies of Protected Health Information.**

5. **PROVIDING ACCESS REQUESTED. PPPSGV is obligated to provide access only if the information is readily producible in a readable form or format. PPPSGV is not obligated to reformat information in a form that is convenient for the requestor.**

6. **TIME AND MANNER OF ACCESS.** If access to inspect is granted, a convenient time or place shall be agreed upon for inspection. If access to obtain a copy is granted, the information shall be mailed to requestor. PPPSGV may limit the scope, format and other aspects of the information as necessary to facilitate timely access.

7. **ELECTRONIC COPIES.** If your health information is maintained electronically, you may request an electronic copy. We will provide it in the format you request (for example, pdf, word file) if the information is readily reproducible in that format. If it is not, we will try to offer you the information in another electronic format. If we cannot offer an electronic format that is acceptable to you, we will provide you with the Health Information in paper copies. If you request, we will provide you electronic copies via email, but this may not be a secure method of transmission.

8. **DENIAL OF A REQUEST FOR ACCESS.** If a request for access is denied, in whole or in part, a written explanation will be provided that contains: a) An explanation of the basis of the denial; b) A statement of review rights, if applicable; and c) A description of how the requestor may complain to PPPSGV or to the Secretary of Health and Human Services ("HHS").

9. **NO RIGHT TO ASK FOR A REVIEW OF A DENIAL.** There is no right to ask for a review if PPPSGV denies a request for access to: a) Any information described in number nine above; b) If PPPSGV created the information while acting under the direction of a correctional institution; c) The information involves research that is in progress and denial of access was agreed to as part of your consent to participate in the research; or d) The information was obtained from a third party under a promise of confidentiality and access would likely reveal the source of the information.

10. **RIGHT TO ASK FOR A REVIEW OF A DENIAL.** There is a right to ask for a review by a second licensed healthcare professional designated by PPPSGV of a denial of a request for access under the following circumstances: a) The initial denial was based on a determination by a licensed healthcare professional that access to the requested information is likely to endanger the life or physical safety of the requestor or another person; or b) The initial denial was based on the determination by a licensed healthcare professional that access to the requested information is likely to cause substantial harm to the requestor or a third person.

11. **EXPIRATION OF AUTHORIZATION. This Authorization will expire within one year of original signature and date, unless otherwise indicated *(insert date):*** _____

12. **REVOCATION OF AUTHORIZATION.** I may revoke this Authorization at any time by notifying PPPSGV in writing, and it will be effective on the date notified except to the extent that PPPSGV has already acted upon such Authorization.

13. **LIMITED USE OF HEALTH INFORMATION.** I understand that health information used or disclosed pursuant to this Authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

14. **AFFECT ON SERVICES PROVIDED.** By authorizing this release of information, my healthcare and payment for my healthcare will not be affected.

15. **COPY OF THIS AUTHORIZATION.** I have the right to receive a copy of this signed Authorization form upon request.

If you are requesting that your information be sent to you or another person by email, you further acknowledge and agree to the risks of transmitting and receiving your information by email, as disclosed in number one of this form, and you agree to release and hold harmless PPPSGV from any liability that may result from using e-mail to communicate with you or another person you may have designated to receive emails that include your Health Information. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using e-mail (except as required by law).

6	***Signature of Patient [OR] Signature of Personal Representative (if required by state law):*** _____ ***Date:*** _____
7	***Office Use only*** ***Form of ID Presented:*** _____ ***Identity Verified By:*** _____