PLANNED PARENTHOOD OF GREATER TEXAS

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION	Name
	DOB
	MR #

I understand Planned Parenthood of Greater Texas ("PPGT") is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization. I specifically authorize PPGT or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient(s) and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

I hereby authorize the release and/or transfer of my health information between the following:

Name	**Name**
Street address	**Street address**
City, State ZIP	**City, State ZIP**
Phone **Fax**	**Phone** **Fax**
Email	**Email**

Description of the information to be used or disclosed (check as appropriate):

☐ **My entire record.** I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record, including but not limited to: demographic information, patient histories, medication lists, and tests. I understand that my medical record may contain sensitive information. (Check box below if HIV/AIDS test results are to be included.)

☐ **I specifically authorize the use or disclosure of any information in my medical record related to**

_____

☐ **HIV/AIDS.** I consent to the release of any test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical record.

Purpose(s) for disclosure of the information:

☐ At my request

☐ Other (specify) _____

Right to revocation. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, PPGT must receive the revocation in writing, and the revocation must include:

- My name and address;
- The effective date of this authorization, and the recipients of the Protected Health Information according to this authorization;
- My desire to revoke this authorization; and
- The date of the revocation and my signature.

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PPGT will accept written revocations of this authorization. You may also complete form PPGT2813 Revocation of Authorization to Disclose Protected Health Information instead of writing out the information listed above. All revocations must be sent to PPGT, and are not effective until received.

This authorization shall expire one year from the date of my signature, or upon completion of the request. After this date/event, PPGT can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization. I have been offered a copy of this signed Authorization form.

Signature of Patient or Representative **Date**

FOR OFFICE USE ONLY
Date request filed
ID presented ☐ yes **Form of ID** ☐ TX driver's license ☐ school ID ☐ other ☐ no, verified identity with name, DOB and another personal identifier
Verification that there is not an alert in EHR concerning the release ☐ no alert ☐ alert present, contacted Privacy Official on:
REQUEST ☐ approved ☐ denied **If denied, Privacy Official notified on:**
Records provided ☐ by mail ☐ in person ☐ email ☐ other:
Date records provided
By staff member