Planned Parenthood®
Care. No matter what.
Planned Parenthood of Maryland

❑	Annapolis	929 West St., Annapolis, MD 21401	410-576-1414	Fax 410-267-9147
❑	Baltimore	330 N. Howard Street, Baltimore, MD 21201	410-576-1414	Fax 410-783-2647
❑	Easton	8579 Commerce Drive #102, Easton, MD 21601	410-576-1414	Fax 410-820-9674
❑	Frederick	170 Thomas Johnson Dr #100, Frederick, MD 21702	410-576-1414	Fax 301-620-9442
❑	Owings Mills	9129 Reisterstown Rd., Owings Mills, MD 21117	410-576-1414	Fax 410-581-9105
❑	Towson	8501 LaSalle Road Suite 309, Towson, MD 21286	410-576-1414	Fax 410-665-6524
❑	Waldorf	3975 St. Charles Pkwy, Waldorf, MD 20602	410-576-1414	Fax 301-645-8696

AUTHORIZATION FORM TO RELEASE OR OBTAIN HEALTH INFORMATION

CLIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____/_____/_____ SS#: _____-_____-_____ MEDICAL RECORD #: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

*Please fill out **one** of the boxes below:*

TO ALLOW PLANNED PARENTHOOD OF MARYLAND TO RELEASE INFORMATION: I authorize Planned Parenthood of Maryland to release information concerning my medical record and/or treatment to:

_____
Name

_____
Street Address

_____
City, State, Zip Code

PHONE: _____

FAX: _____

TO REQUEST INFORMATION FROM AN OUTSIDE HEALTH CARE PROVIDER: I authorize the provider named below to release information concerning my medical record and/or treatment to Planned Parenthood of Maryland (send records to the Health Center identified above):

_____
Name

_____
Street Address

_____
City, State, Zip Code

PHONE: _____

FAX: _____

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information: DATES:

- ❑ Entire Medical Record, OR (check the appropriate box(s)) _____
- ❑ History and physical exam _____
- ❑ Substance abuse (including alcohol/drug abuse) _____
- ❑ Lab reports / Radiology reports _____
- ❑ Mental health (including psychotherapy notes) _____
- ❑ HIV related information (AIDS related testing) _____
- ❑ Other: _____ _____

CONDITIONS OF AUTHORIZATION:

1. This Authorization will expire on (insert date or event): _____
2. I may revoke this Authorization at any time by notifying Planned Parenthood of Maryland in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Maryland 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.
6. I have been informed that Planned Parenthood of Maryland ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

X_____ OR _____
Client Signature Date Parent/Legal Guardian/Authorized Person Date

FOR OFFICE USE ONLY
Date Request Filled: _____ By: _____
Form of Identification Presented: _____