Planned Parenthood®
Care. No matter what.
Planned Parenthood Arizona, Inc.

PATIENT AUTHORIZATION TO USE / RELEASE HEALTH INFORMATION

PATIENT INFO

Patient Last Name | **Patient First Name** | **Maiden Name / Other Last Name**

Date of Birth: Month Day Year | **Address** | **City / State / Zip**

Primary Phone *(with area code)* | **Secondary Phone** *(with area code)* | **Email** *(optional)*

RECORDS / PURPOSE

Purpose of record request:

☐ Personal ☐ Continuing Care ☐ Legal ☐ Insurance ☐ Other: _____

Records requested include:

☐ Entire Medical Record *(Includes history, visit notes, tests, image results)*
HIV/AIDS & STI results will not be included unless checked below.

☐ HIV/AIDS Testing / Results
Check here to include in records

☐ STI Testing / Results
Check here to include in records

☐ Images and Films
☐ Lab Tests / Results
☐ Office Visit
☐ Other: _____

Date Range of Records Requested: From _____ To _____

DELIVERY OF RECORDS

I authorize PPAZ to release my health information to:

☐ Myself
☐ The facility listed below.
☐ The person listed below.

I authorize PPAZ to release my health information by:

☐ Email *Email will be sent from medicalfax@ppaz.org.*
☐ Fax *Fax will be sent from 602-296-0154.*
☐ Mail to below address. The return label will only identify the Admin Office street address.
☐ In-person pick up at Admin Office at 4751 N. 15th Street, Phoenix, AZ 85014. *We will call you when your records are ready.*

I authorize PPAZ to request my health information from:

☐ The facility listed below.

Release records to PPAZ by fax.

PPAZ Fax Number: _____

Name / Provider / Facility

Street Address | **City / State / Zip**

Email | **Fax Number** *(with area code)* | **Phone Number** *(with area code)*

HEALTH CENTER LOACTIONS

Please mark the health centers where you received care:

Current Health Center Locations:

☐ **Central**
4751 N 15th Street
Phoenix, AZ 85014

☐ **Mesa**
1235 S. Gilbert, #7
Mesa, AZ 85204

☐ **Flagstaff**
2500 S. Woodlands Village Blvd, #12
Flagstaff, AZ 86001

☐ **Southern Arizona**
2255 N Wyatt Dr
Tucson, AZ 85712

☐ **Glendale**
5771 W Eugie
Glendale, AZ 85304

☐ **Tempe**
1837 E. Baseline Rd
Tempe, AZ 85283

☐ **Desert Sky**
2020N. 75th Avenue, #11
Phoenix, AZ 85035

Former Health Center Locations:

☐ **Archer Center**
1665 S La Cholla Blvd
Tucson, AZ 85713

☐ **Mesa**
1235 S. Gilbert, #20
Mesa, AZ 85204

☐ **Southwest Valley**
140 N Litchfield Rd
Goodyear, AZ 85323

☐ **Central Phoenix**
5651 N 7th Street
Phoenix, AZ 85014

☐ **Northeast Phoenix**
3131 E Thunderbird, #48
Phoenix, AZ 85032

☐ **Tempe**
1250 E Apache, #108
Tempe, AZ 85281

☐ **Chandler**
610 N Alma School Rd
Chandler, AZ 85224

☐ **Prescott**
656 W Gurley
Prescott, AZ 86305

☐ **Yuma**
1455 W 16th St #C
Yuma, AZ 85364

☐ **Hoffman Center**
529 W Wetmore Rd
Tucson, AZ 85705

☐ **Scottsdale**
7901 E Thomas #106
Scottsdale, AZ 85251

☐ **Tucson Women's Center**
5240 E. Knight Dr, #112
Tucson, AZ 85712

☐ **Maryvale**
4616 N 51st Ave #210
Phoenix, AZ 85031

SIGN HERE

I understand the following:

This Authorization will expire one year from the date signed or before if noted ***(insert date or event)*:**_____.
I may revoke this Authorization at any time by notifying Planned Parenthood Arizona in writing, and it will be effective on the date notified, except to the extent that Planned Parenthood Arizona has already acted upon such Authorization. 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. 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. I have been offered a copy of this signed Authorization form.

_____ ***(Initial)**** I understand if I request my personal health information be sent via email to myself or another person, Planned Parenthood Arizona (PPAZ) cannot guarantee complete HIPAA security across unsecure channels. By initialing, you agree to release and hold harmless PPAZ from any liability that may result from using e-mail to communicate with you or another person regarding your personal health information. It is PPAZ's official recommendation, in order to ensure the most secure transfer of health information occurs, that personal health information be faxed, mailed, or picked up in person.

Signature of Patient / Legal Guardian / Authorized Person	**Relationship to patient**	**Date**

Patient signature if records received at time of request	**Health Center Staff Signature**	**Date**

**You can submit your request by:

- Fax: (602) 296-0154
- Email: MedicalFax@ppaz.org
- In person at any of our current health centers.

Please allow up to 10 business days to process your request.

OFFICAL USE

Form of Identification	**State / Country / Territory**	**Identification Number**

Completed by	**Date Completed**