Authorization:
Release of Medical Information

CLINIC ADDRESS LABEL HERE

PATIENT LABEL HERE

PLEASE COMPLETE

Patient name: ______________________________

Date of birth: ______________________________

I, THE UNDERSIGNED, HEREBY AUTHORIZE PPGOH TO:

___Release*   ___Obtain

INFORMATION CONTAINED IN MY MEDICAL RECORD TO/FROM:

Health provider: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ____________________ Fax: ______________

THE FOLLOWING INFORMATION IS NEEDED FOR CONTINUITY OF CARE:

___Pelvic exam

___Breast exam

___Pap/Pathology results

___Record of last Depo injection

___Colposcopy results

___Colposcopy exam notes/plan of care

___Procedure notes

___Laboratory tests

___Other: ______________________________

This Authorization is made for the following purpose: ___At my request, OR ___Specify:______________________

*If releasing records to another provider:

PP location where you were last seen:______________________ Year of your last visit at that location:__________

CONDITIONS OF AUTHORIZATION

1. This Authorization is valid for ninety (90) days.
2. I may revoke this Authorization at any time by notifying Planned Parenthood in writing, and it will be effective on the date notified except to the extent that Planned Parenthood 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.

Patient signature: ______________________________________ Date:________________

Witness: ______________________________________ Date:________________

FOR OFFICE USE ONLY. Date request filled:____________ By:______________________________

Identification presented:____________________ Form of identification:______________________________