AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Planned Parenthood of the Great Northwest and the Hawaiian Islands | 800-769-0045

Planned Parenthood®
Care. No matter what.

Patient Name: _____ Medical Record #: _____
(last, first, middle initial)

Date of birth: ____/____/____ Social Security #: ____-____-____

Address: _____ City: _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

HEALTH INFORMATION TO BE RELEASED BY:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

HEALTH INFORMATION TO BE RELEASED TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

To send a request and/or record to Planned Parenthood, please contact:
PPGNHI Records Request, 140 Hoohana St # 303, Kahului, HI 96732 | Phone: 206-858-4880
If you are sending medical records to PPGNHI | Fax: 206-788-8337
If you are requesting records from PPGNHI | Fax: 206-788-8339

PURPOSE OF DISCLOSURE: ☐ Continue care ☐ Other: _____

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:

☐ Entire medical record

Or, check the appropriate boxes:

☐ Most current physical exam ☐ Most current pap result ☐ Other: _____
☐ Most current lab results ☐ Contraception history

MY AUTHORIZATION ACKNOWLEDGES THAT:

Information released may include information regarding testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted diseases, chemical dependency, or mental/psychiatric illness. I give my specific authorization for this information to be released.

I REQUEST THAT THE INFORMATION BE PROVIDED IN THE FOLLOWING FORMAT:

☐ Paper copies ☐ Copied onto a CD that will be mailed to me or that I may pick up

CONDITIONS OF AUTHORIZATION:

This Authorization will expire **one year** from the date signed, or before if noted: _____. I may revoke this Authorization at any time by notifying Planned Parenthood of the Great Northwest and the Hawaiian Islands in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of the Great Northwest and the Hawaiian Islands 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.

_____
Signature of client *Date*