Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the use and disclosure of my health information as described below:

|  |  |
| --- | --- |
| Person/organizations **providing** the information:  **Name** Planned Parenthood of Northern New England | Person/organizations **receiving** the information:  **Name** |
| **Street (all locations)** | **Street** |
| **City, State, ZIP** | **City, State, ZIP** |
| **Telephone**  866-476-1321 | **Telephone** |
| **Fax**  802-448-9714 | **Fax** |

I give permission for the receiving persons/organizations to send health information back to the providing persons/organization.

I understand that if I refuse to release all or some of my health information, it may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other insurance or other adverse consequences.

**I specifically authorize release of the following information:**

**Release files in the Medical Record**

* **Date Range of Records (this information MUST be completed)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do not release the following**

I DO NOT want information relating to HIV test results, status, or treatment released

I DO NOT want information relating to participation in an Alcohol or Drug Abuse Treatment Program released

I DO NOT want information relating to diagnosis or treatment of Mental Health released

I DO NOT want information relating to abortion services released

OTHER CONDITIONS (please clearly specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This Authorization is made for the following purpose:**

 At my request  Other:

**CONDITIONS OF AUTHORIZATION**

1. This Authorization will expire 12 months from the date of signing or until I cancel this authorization.
2. I may cancel this Authorization at any time during the above period by notifying PPNNE in writing, and it will take effect on the day the request is received, except where the records have already been released.
3. Not agreeing to or canceling this authorization may be basis for denial of health benefits or other insurance coverage or benefits, but is not a condition for medical treatment.
4. I understand that if the person/organization that receives the Health Information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.
5. I understand that I may have a copy of this signed Authorization form if I ask for one.
6. I understand that if information on where to send or forward your protected health information or medical records is not complete, and we are unable to reach you for clarification, this request will not be fulfilled.

**PATIENT SIGNATURE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Relationship of Personal Representative of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Affix patient label here or write:*

Name: Birthdate:

Patient #: