MT. BAKER PLANNED PARENTHOOD
Authorization Form for Release of Health Information

Patient Name ____ Date of Birth ____________________

Address ____
(Street) (City) (State) (Zip)

Work Phone (_______) ________-_______________ Home Phone (_______) ________-_______________

I. Release my records:

FROM: ________________________________ To: ________________________________

________________________________ ________________________________

________________________________ ________________________________

II. Reason for release: ☐ **Treatment** ☐ **Other:** (specify) ________________________________

III. Information to release: Information requiring special consent will only be included if indicated separately below.

☐ Last annual exam including Pap result, breast and pelvic exam, all lab tests and chart notes

OR

☐ Only the following (please specify): ____

IV. I authorize you to release above from my current medical record.

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health care information for a third party.
- I may revoke this authorization in writing; if I did, it would not affect any actions already taken by Mt. Baker Planned Parenthood based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
  1. Fill out a revocation form available at all of our clinics.
     – Or –
  2. Write a letter to Mt. Baker Planned Parenthood, 1509 Cornwall Avenue, Bellingham, WA 98225.
- Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.
- I have been offered a copy of this signed Authorization Form for Release of Health Information.
- This authorization shall become effective immediately and shall remain in effect 90 days from date below.

____ ________________________________

Patient or legally authorized individual signature Date Time

IV. I additionally authorize you to release the following from my current medical record.

- The same conditions listed above apply to this release of information.
- My additional signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

☐ HIV/AIDS virus ☐ Mental Health/Psychiatric disorders

☐ Sexually Transmitted Diseases ☐ Drug, Alcohol Abuse/Treatment

____ ________________________________

Patient or legally authorized individual signature Date Time

STAFF USE

This request expires 90 days from the date signed. Expiration Date: ________________________________