AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Planned Parenthood®

of South, East and North Florida

☐	**Tallahassee** 2618 W Tennessee St Tallahassee, FL 32304	(850) 574-7455…..Fax (850) 575-4335
☐	**Gainesville** 914 NW 13 Street Gainesville, FL 32601	(352) 377-0881.....Fax (352) 374-6823
☐	**Jacksonville** 5978 Powers Ave Jacksonville FL 32217	(904) 399-2800……Fax (904) 399-2525
☐	**Martin County** 1322 NW Federal Hwy., Stuart, FL 34994,	(772) 692-2023….. Fax (772) 692-1555
☐	**West Palm Beach** 931 Village Blvd., Suite 904 WPB, FL 33409,	(561) 683-0302……Fax (561) 683-9823
☐	**Wellington** 1011 1 Forest Hill Blvd Suite# 340 Wellington, FL 33414	(561) 296-4919…..Fax (561) 721-3474
☐	**Boca Center** 8177 Glades Rd, Bay 25, Boca Raton, FL 33434	(561) 226-4116……Fax (561) 939-1344
☐	**Pembroke Pines** 263 N University Dr, Pembroke Pines, FL 33024	(954) 989-5747……Fax (954) 989-2371
☐	**Golden Glades** 585 NW 161st St. Miami, FL 33169	(305) 830-4111……Fax (305) 830-4101
☐	**Miami Jean Shehan** 1378 Coral Way, Miami, FL 33145,	(305) 285-5535……Fax (305) 285-6956
☐	**Kendall** 8900 SW 117th Ave Suite 207B Miami, FL 33186	(786) 263-0001……Fax (786) 263-0004

CLIENT NAME:

_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____ CHART NUMBER #: _____
MO DAY YR

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF SOUTH, EAST AND NORTH FLORIDA

OBTAIN or RELEASE MY HEALTH INFORMATION TO or FROM:
(CIRCLE ONE) (CIRCLE ONE)

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ FAX: _____

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of information:

_____ Visit Summary's

_____HIV test results

_____ Pap smear reports

_____ STI results (sexually transmitted infections)

_____ Biopsy results

_____ Ultrasound results

_____ Mammogram results

_____ Mental Health records or reports

_____ Records from other providers that Planned Parenthood may have in their possession

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire in twelve (12) months after date of authorization unless otherwise noted:
   _____

2. I may revoke this Authorization at any time by notifying plat, Inc. in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of South, East and North Florida. 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.

_____ OR _____

SIGNATURE OF CLIENT AUTHORIZED PERSON

DATE _____ DATE _____

DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FORM OF IDENTIFICATION: _____

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