Planned Parenthood
Care. No matter what.
Planned Parenthood Southeastern Pennsylvania

Medical Records Release

Patient's Name:_____ **Birthdate:**_____

PPSP charts routinely contain information regarding sexually transmitted disease, sexual and drug use history. This information might indicate the patient's risk of contracting HIV. (HIV, or Human Immunodeficiency Virus, is the virus which causes AIDS or HIV infection.) Other HIV-related information includes whether the patient has had a test for HIV, an HIV related illness or AIDS. **This is a standard Planned Parenthood medical records release for all patients created to comply with PA Act 148. It does not mean that this patient is at risk for HIV infection.**

I authorize _____
Name of Institution or Person (releasing medical records)

_____ to release medical records including possible HIV-related information to:
Address (city, state, zip code)

_____
Name of Institution or Person (receiving medical records)

_____
Address (city, state, zip code)

[ ] Medical records from my visits during the period from _____ to _____ at _____
(location of clinic is required)

[ ]Specify how much and what kind of information is to be released: _____

_____

The above information is to be released for the following purpose(s) only:_____

This authorization must be signed and dated. I may revoke this consent at any time by contacting the Privacy Officer at Planned Parenthood Southeastern Pennsylvania unless information has already been released in reliance on this form. It is therefore possible that the recipient could redisclose information used or disclosed under this Authorization and no longer be subject to privacy protections provided by law.

This consent will expire on: Date _____

I have read and fully understand the above statements as they apply to me. I consent to the release of records for the purpose stated above. I agree not to sue or hold Planned Parenthood Southeastern Pennsylvania, its employees, or agents responsible for any problems caused by the release of this information. I understand that Planned Parenthood may not require that I sign this Authorization as a condition of my receiving treatment, except if the treatment is related to a research project.

Patient's Signature:_____ Date:_____

Witness:_____
title/relationship to patient

Patient is unable to sign for the following reason:_____

Signature of Authorized Representative: _____
relationship to patient Date

Staff Witness:_____
title Date