Planned Parenthood
Pasadena & San Gabriel Valley

AUTHORIZATION AND REQUEST FOR ACCESS TO HEALTH INFORMATION

- Alhambra Health Center | 330 S. Garfield Ave. Suite 300, Alhambra, CA 91801
- Baldwin Park Health Center | 4070 Sterling Way, Baldwin Park, CA 91706
- Glendora Health Center | 130 W. Route 66, Suite 100, Glendora, CA 91740
- Highland Park Health Center | 5903 N. Figueroa St. Highland Park, CA 90042
- Pasadena Health Center | 1045 N. Lake Ave. Pasadena, CA 91104

1	**Patient Name:**	**Patient Date of Birth (MM/DD/YYY):**
	Patient Address:	**Patient Phone:**
	Email Address:	
	PATIENT REQUEST	
2	***Please Note: you may access on-demand summaries of your visits in our Patient Portal by logging in here:*** ***https://www.medfusion.net/plannedparenthoodofpasadena-27611/portal/#/user/login*** ***If you are not yet enrolled, you may call our Contact Center at 626-798-0706 to request log in access.*** I HEREBY REQUEST access to *☐ inspect or ☐ obtain a copy* (check the box that applies) of my health information held by Planned Parenthood Pasadena and San Gabriel Valley. I request that the information be provided in the following format (select from Box 3 or 4).	
3	☐ Paper Copy (Select one): ☐ Self pick up ☐ Fax to: __________________ ☐ Mail ☐ To you at address in Box 1 ☐ To someone else at the address below:	
	Recipient Name:	
	Recipient Address:	
4	☐ Electronic Copy (available only for information maintained electronically). ☐ Email to you at address in Box 1. ☐ Email to someone else at the email address: ________________________________ IF YOU WISH HEALTH INFORMATION TO BE SENT TO YOU OR SOMEONE ELSE VIA EMAIL, PLEASE READ SECTION 1,"RISKS OF USING EMAIL", IN THE CONDITIONS FOR AUTHORIZATION.	
5	This purpose or need for this access is for (check one or more): ☐ Further Medical Care ☐ Personal Use ☐ Legal ☐ Insurance ☐ Other (*Specify*) _________________________	
6	☐ I HEREBY AUTHORIZE Planned Parenthood Pasadena and San Gabriel Valley to release my health information to (Recipient below) ☐ I HEREBY AUTHORIZE (Provider below) to release my health information to Planned Parenthood Pasadena and San Gabriel Valley: Email to: pppsgvsecuremessage@pppsgv.org ☐ Fax to: (626) 798-2919 ☐ Fax to other: ________________________	
	Recipient Name:	**Recipient Phone:**
	Recipient Address:	**Recipient Fax:**

7	HEALTH INFORMATION TO BE RELEASED I specifically authorize release or receipt of the following information for the following date range (MM/DD/YYYY): *From* _____________ *to* _______________ ❑ Lab reports related to: __________________ ❑ All lab reports (Does not include HIV results) ❑ Visit summaries (Includes physical exam but excludes alcohol/drug information and mental health/behavioral health notes) ❑ Patient history ❑ Vaccination records ❑ Records from receiving facility to which I may be transferred (For patients being transferred or referred out only) ❑ Records related to a specific injury, treatment or other purpose (specify): ______________________________ **NOTE: Records may include information related to mental health, alcohol or drug use, and HIV or AIDS. However, treatment records from mental health and alcohol or drug departments, and/or results of HIV tests will not be specifically disclosed unless specifically requested (check all that apply):** ❑ HIV test results ❑ Mental health/behavioral health treatment records (other than psychotherapy notes) ❑ Psychotherapy notes **(Authorization for the use or disclosure of psychotherapy notes may not be combined with any other authorization; if this box is checked with other boxes, another authorization will be required)*** Alcohol/drug treatment/referral records ❑ Other: ____
8	Unless otherwise revoked, this Authorization expires ________________ (insert applicable date or event). If no date is indicated this Authorization will expire 12 months after the date signed below.

CONDITIONS OF AUTHORIZATION

1. **RISKS OF USING E-MAIL** to receive your health records: E-mail may not be reliable, secure, or private. For example:
   - E-mail can be hacked. (Unauthorized people can intercept it, alter it or use it).
   - E-mail can be sent to the wrong person, lost or subject to other sending errors.
   - E-mail may come from someone other than the named sender.
   - E-mail is easier to fake than handwritten, signed papers.
   - Anyone with access to an e-mail account will have access to all messages in that account. This includes those who have permission to use the e-mail account as well as those who do not.
   - Anyone who gets or has access to an e-mail can read, forward, copy, delete or change it. This includes those who have permission to use the e-mail account as well as those who do not.
   - Any deleted e-mails can be found again.
   - E-mail services have a right to save and check e-mail sent through their system.
   - E-mail can spread viruses.
   - You should not receive your health information via email if people who you don't want to view your medical information have access to your e-mail account.

2. **MENTAL HEALTH/BEHAVIORAL HEALTH TREATMENT RECORDS.** The mental health care provider who was in charge of your care may deny release of your information in limited circumstances.

3. **PSYCHOTHERAPY NOTES.** The law does not entitle you to access to inspect or obtain a copy of psychotherapy notes. The mental health care provider who was in charge of your care may deny release of these notes. These notes are primarily for personal use by the treating professional and generally not disclosed for other purposes.

4. **TIME FOR RESPONSE.** Planned Parenthood Pasadena and San Gabriel Valley (PPPSGV) has up to five (5) working days after receipt of the written request to respond to a request for inspection and fifteen (15) days after receipt of this request to provide copies.

5. **PROVIDING ACCESS REQUESTED.** Health information is available to all patients through the Patient Portal. If copies of health information is requested, PPPSGV shall attempt to fulfill each request in the manner requested. For example, if the requestor asks that health information be sent to a particular email address in PDF format, PPPSGV shall attempt to send the information in that manner. PPPSGV may seek to fulfill the request in an alternative manner if PPPSGV is technically unable to fulfill the request in the preferred manner or if PPPSGV cannot reach agreement with the requestor regarding the means of fulfilling the request.

6. **TIME AND MANNER OF ACCESS.** If access to inspect is granted, a convenient time during business hours or place shall be agreed upon for inspection. If access to obtain a copy is granted, the information shall be mailed to requestor unless otherwise agreed.

7. **DENIAL OF A REQUEST FOR ACCESS.** PPPSGV may decline to disclose health information if PPPSGV has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person. If a request for access is denied, in whole or in part, PPPSGV must provide a written denial with: a) the basis for the denial; b) a statement of review rights, if applicable; and c) a description of how the requestor may complain to PPPSGV or to the Secretary of Health and Human Services ("HHS").
8. **RIGHT TO ASK FOR A REVIEW OF A DENIAL.** There is a right to ask for a review by a second licensed healthcare professional designated by PPPSGV of a denial of a request for access is for the reason in paragraph 7 above.
9. **NO RIGHT TO ASK FOR A REVIEW OF A DENIAL.** There is no right to ask for a review if PPPSGV denies a request for access: a) to psychotherapy notes; b) the information involves research that is in progress and denial of access was agreed to as part of the consent to participate in the research; or d) the information was obtained from a third party under a promise of confidentiality and access would likely reveal the source of the information.

If you are requesting that your information be sent to you or another person by email, you further acknowledge and agree to the risks of transmitting and receiving your information by email, as disclosed in this form, and you agree to release and hold harmless PPPSGV from any liability that may result from using e-mail to communicate with you or another person you may have designated to receive emails that include your Health Information. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using e-mail (except as required by law).

I understand that by signing this authorization:

- **I authorize the use and/or disclosure of my individually identifiable health information at the request of the patient (myself). I understand that this authorization is voluntary.**
- **I have the right to revoke this authorization at any time by sending a signed written notice revoking this authorization to the address on page one. The authorization will cease on the date my valid revocation request is received, but will not apply to information disclosed before receipt of the written request.**
- **My treatment, payment, enrollment or eligibility for benefits will not be affected whether I sign or do not sign this authorization.**
- **Under California law, the recipient of my medical information is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law.**
- **If the organization or person I have authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal law.**
- **I have a right to receive a copy of this authorization.**

6	Signature of Patient OR Signature of Personal Representative (if required by state law)**:** ______________________________ Date: ______________ If personal representative, relationship to patient: ______________ Date: ________
7	**Office Use Only** *Form of ID Presented*:______________ Verified over phone: ______________ *Identity verified by:*______________