

POLK COUNTY REPRODUCTIVE HEALTH SERVICES

Consent for Release of Confidential Information

Client Name: _____		Birthdate ____/____/____	
Address: _____ _____		Telephone: _____	Home: _____ Cell: _____ e-mail: _____
I HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION:			
FROM: _____ _____ _____		TO: _____ _____ _____	
HEALTH INFORMATION TO BE RELEASED:			
I specifically authorize release of the following information: <input type="checkbox"/> Most recent Reproductive Health History & Physical Exam record <input type="checkbox"/> Most recent Pap test & results <input type="checkbox"/> Most recent STI screen & results <input type="checkbox"/> Depo-Provera injection dates <input type="checkbox"/> Other (specify) _____		Dates Requested: _____ _____ _____ _____	
FEDERAL REGULATIONS STATE THAT DISCLOSURE OF THE FOLLOWING INFORMATION MUST BE SPECIFICALLY CHECKED:			
<input type="checkbox"/> HIV/ARC/AIDS		<input type="checkbox"/> Treatment for AODA/Mental Health	<input type="checkbox"/> All Mental Health information/evaluations
This information is needed for continuity of care or for the following specific purpose(s): _____			
CONDITIONS OF AUTHORIZATION:			
1. This Authorization will expire on ____/____/____ or automatically expire six (6) months following the date of my signature without my express revocation. 2. I may revoke this Authorization at any time by notifying PCRHS in writing, and it will be effective on the date notified except to the extent that PCRHS has already acted up on 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. Polk County Reproductive Health Services will not penalize me if I do not sign this Authorization. 5. I have been offered a copy of this Authorization form.			
Client Signature _____		Date ____/____/____	
Staff Signature _____		Date ____/____/____	