

PLANNED PARENTHOOD OF SOUTH CENTRAL MICHIGAN

4201 W. Michigan Ave., Kalamazoo, MI 49006

Phone: (269) 372-1200 Fax: (269) 372-1279

Also in: Battle Creek (269) 964-0885 • Coldwater (517) 279-7902 • Hillsdale (517) 437-4278

Sturgis (269) 651-8147 • Three Rivers (269) 273-3658

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME:

LAST FIRST MI
ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: ____-____-____ PHONE: _____

CHART #: _____

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF SOUTH CENTRAL MICHIGAN (PPSCM) TO:

- 1. RELEASE MY HEALTH INFORMATION TO
- 2. OBTAIN MY HEALTH INFORMATION FROM

NAME OF DOCTOR OR CLINIC:

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information:

DATES:

- Entire Medical Record, OR (check the appropriate box(s)) _____
- Last Annual exam _____
- Physical exam _____
- Lab reports –including Pap Smear _____
- Radiology Reports _____
- Other: _____

This Authorization is made for the following purpose:

- At my request, OR
- Specify: _____

SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

FOR OFFICE USE ONLY	
DATE REQUEST FILLED: _____	BY: _____
IDENTIFICATION PRESENTED: _____	FORM OF IDENTIFICATION: _____

