Planned Parenthood
of Southeast Ohio, Inc.

Authorization for Release of Medical Information to PPSEO

PATIENT NAME:_____
LAST FIRST MI MAIDEN

PATIENT DATE OF BIRTH:_____
MONTH DAY YEAR

PATIENT SOCIAL SECURITY NUMBER:_____

For the purpose of continuing my health care, I authorize

NAME OF HEALTH CARE PROVIDER:_____

ADDRESS:_____ **PHONE:**_____

_____ **FAX:**_____

to release my medical information via mail or fax to Planned Parenthood of Southeast Ohio:

ATTENTION:_____

1005 E. State Street
Athens OH 45701
740-593-6979
Fax: 740-593-8223

The following information is needed for continuity of care:

- ❑ Pelvic Exam
- ❑ Breast Exam
- ❑ Pap Pathology Results
- ❑ Progress Notes for Last Depo Injection
- ❑ Laboratory Tests_____
- ❑ Colposcopy Results
- ❑ Procedure Notes
- ❑ _____

CONDITIONS OF AUTHORIZATION

1. This Authorization is valid for ninety (90) days.
2. I may revoke this Authorization at any time by notifying PPSEO in writing, and it will be effective on the date notified except to the extent that PPSEO 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.

PATIENT SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION