Planned Parenthood®
Care. No matter what.
Planned Parenthood of Montana

Date of Request: _____

AUTHORIZATION FORM TO REQUEST / RELEASE HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: _____-_____-_____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____
DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF MONTANA TO REQUEST / RELEASE MY HEALTH INFORMATION FROM / TO:

NAME: _____

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

PHONE: _____ FAX: _____

HEALTH INFORMATION TO BE REQUESTED / RELEASED:

I specifically authorize release of the following information:

DATES:

- ❑ Entire Medical Record, OR (check the appropriate box) **LATEST RESULTS:** _____
- ❑ History and physical exam, including Breast Exam _____
- ❑ Progress notes _____
- ❑ Substance abuse (including alcohol/drug abuse) _____
- ❑ Lab reports: GC ____ Chlamydia:_____ PAP: _____ Other: _____ _____
- ❑ Mental health (including psychotherapy notes) _____
- ❑ Ultrasound reports _____
- ❑ HIV related information (AIDS related testing) _____
- ❑ Other: _____ _____

This Authorization is made for the following purpose:

- ❑ At my request, OR Specify: _____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on (insert date or event): _____
2. I may revoke this Authorization at any time by notifying Planned Parenthood of Montana in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Montana 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. I have been offered a copy of this signed Authorization form.
5. I have been informed that Planned Parenthood of Montana ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

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

100 W. Wicks Lane Billings MT 59105 (P) 406-869-5040 (F) 406-294-8643	1844 Broadwater Ave Billings MT 59102 (P) 406-656-9980 (F) 406-656-9928	211 9th Street South Great Falls MT 59405 (P) 406-454-3431 (F) 406-454-3433	1500 Cannon St Helena MT 59601 (P) 406-443-7676 (F) 406-443-2351	219 East Main Missoula MT 59802 (P) 406-728-5490 (F) 406-728-5497	**After Hours** for all clinics: 1-888-867-8961