Planned Parenthood®
Care. No matter what.

Planned Parenthood Southwest Ohio Region

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

☐ **Campbell Center/Medical**
2314 Auburn Ave.
Cincinnati, Ohio 45219
(513) 287-6484
(513) 287-6580 (fax)

☐ **Campbell Center/Surgical**
2314 Auburn Ave.
Cincinnati, Ohio 45219
(513) 287-6488
(513) 287-6496 (fax)

☐ **Dayton Center**
224 N. Wilkinson St.
Dayton, Ohio 45402
(937) 226-0780
(937) 226-0355 (fax)

☐ **Hamilton Center**
11 Ludlow Ave.
Hamilton, Ohio 45011
(513) 856-8332
(513) 856-8931 (fax)

☐ **Mary M. Yeiser Center**
2016 Ferguson Rd.
Cincinnati, Ohio 45238
(513) 574-4348
(513) 574-4382 (fax)

☐ **Springdale Center**
290 Northland Blvd.
Cincinnati, Ohio 45246
(513) 772-2207
(513) 772-2469 (fax)

☐ **Springfield Center**
1061 North Bechtle Ave.
Springfield, Ohio 45504
(937) 325-7349
(937) 325-5632 (fax)

PatientName:____
LAST FIRST MI MAIDEN OR OTHER NAME

Date of Birth:_______/_______/______ Social Security #:________-______-________ Chart Number:___________________

Address:____
STREET CITY STATE ZIP

Daytime Telephone Number:________________________________ Evening Telephone Number:______________________________

I hereby authorize Planned Parenthood Southwest Ohio Region to **OBTAIN/RELEASE** my health information **FROM/TO**:

Name:____

Address:____
STREET CITY STATE ZIP

Phone Number:__________________________________ Fax Number:_________________________________

HEALTH INFORMATION TO BE RELEASED

I specifically authorize release of the following information: Dates:

☐ Entire Medical Record, **OR** (check the appropriate box(s)) ______________________
☐ History and physical exam ______________________
☐ Progress notes ______________________
☐ Substance abuse (including alcohol/drug abuse) ______________________
☐ Lab reports ______________________
☐ Mental health (including psychotherapy notes) ______________________
☐ X-ray 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 in 90 days from date of signature below, OR ☐ ____.
2. I may revoke this Authorization at any time by notifying Planned Parenthood Southwest Ohio Region in writing, and it will be effective on the date notified except to the extent that Planned Parenthood Southwest Ohio Region 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.
5. I have been offered a copy of this signed Authorization form.
6. [If this authorization is for Marketing: I have been informed that Planned Parenthood Southwest Ohio Region 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

FOR OFFICE USE ONLY:

Planned Parenthood Southwest Ohio Region

Date Request Filled: _____________ By: ____________________ Identification Presented: YES / NO Form of Identification: _________________