



Planned Parenthood North Central States-PPMNS

RELEASE OF INFORMATION FROM
PLANNED PARENTHOOD
NORTH CENTRAL STATES-PPMNS

PATIENT NAME (legal name): LAST FIRST MI MAIDEN/OTHER MRN:

PREFERRED NAME (if different from legal name):

DATE OF BIRTH: PHONE:

I HEREBY AUTHORIZE TO RELEASE MY HEALTH INFORMATION

Table with 2 main columns: FROM: Planned Parenthood North Central States-PPMNS and TO: Name: (Person or Organization). Includes address and contact information for both parties.

HEALTH INFORMATION TO BE RELEASED

Release the records marked below for this condition or date(s) of treatment: (If blank we will release 2 years' worth of most recent records.)

[ ] Pertinent Medical records (Includes progress notes, labs/pathology, diagnostics, operative/procedure reports, medication, immunizations, medical history)

OR to only release specific portions of your health information, indicate the categories to be released:

- [ ] Clinic visit/Progress Note [ ] Diagnostic Results
[ ] Laboratory/Pathology Results [ ] Operation/Procedure
[ ] Medications [ ] Immunizations
[ ] Psychotherapy Records [ ] Entire Medical Record (charges may apply)
[ ] Billing Records [ ] Other:

Reason for Release of Information (e.g., continuing care, legal, insurance purposes):

All records of treatment for psychiatric/mental health, chemical dependency, STIs and HIV/AIDS- related illness or testing will be released for the dates or conditions given above unless indicated here:

[ ] This authorization pertains to records created prior to date of signature and after date of signature

Conditions of Authorization

- 1. This authorization lasts for one year after the date you sign it unless you enter another date here:
2. I may cancel this authorization at any time by Planned Parenthood North Central States-PPMNS in writing, and it will be effective on the date notified except to the extent that PPMNS has already acted upon such Authorization.
3. Planned Parenthood North Central States-PPMNS cannot prevent redisclosure of my information by the person or organization that receives it, and that information may not be covered by federal and state privacy protections after it is released.
4. Planned Parenthood North Central States-PPMNS will not penalize me if I do not sign this authorization.
5. I have been offered a copy of this signed Authorization form.

Patient's signature: Date:

OR legally authorized representative's signature: Date: