Planned Parenthood
Orange and San Bernardino Counties

MELODY
WOMEN'S HEALTH

Planned Parenthood/Orange and San Bernardino Counties, Inc.
Corporate Offices
Attention: Medical Records Clerk
700 S. Tustin St.
Orange, CA 92866
714-633-6373 (Main)

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

Patient Name: ____

DOB: ________________ SSN: ____________________ MR#: __________

Patient Address: ____

____

Day Phone: ______________ Evening Phone: _____________

➢ ***Please Note**: if you are requesting your records remotely, PPOSBC will require proof of your identification to review your request. Please enclose with this request, a copy of your valid and current photo ID (Driver's License, State ID, School ID, other photo ID). PPOSBC will review your request and proof of ID.*

To authorize Planned Parenthood Orange and San Bernardino Counties to release your health information to yourself, another health care provider or other third party, complete the following section:

❑ **I HEREBY AUTHORIZE PLANNED PARENTHOOD ORANGE AND SAN BERNARDINO COUNTIES TO RELEASE MY HEALTH INFORMATION TO:**

NAME: ____

ADDRESS: ____

CITY: ______________________________ STATE: ___ ZIP: __________

PHONE: ______________________ FAX: __________________________

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To authorize another health care provider to release your health information *<u>to Planned Parenthood Orange and San Bernardino Counties,</u>* *complete the following section:*

❑ **I HEREBY AUTHORIZE (NAME):** ______________________________

ADDRESS: ______________________________

CITY: ______________________ STATE: ___ ZIP: __________

PHONE: ____________________ FAX: ____________________

To release my health information to:
Planned Parenthood/Orange and San Bernardino Counties
Attention: Medical Records Clerk
700 S. Tustin St.
Orange, CA 92866

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release or receipt of the following information.

❑ **Check the appropriate box(es) below for each category(ies) you authorize:**
(Specific Dates per test required —including HIV:↓)

		Date/Date Range
☐	Ultrasound report/Imaging	______________
☐	Pap smear records	______________
❑	Progress notes	______________
❑	***HIV related information (AIDS related testing)**	______________
❑	Lab reports (please specify which Lab report)	______________
❑	Immunization records (please specify which)	______________
❑	Other (please specify): ______________	______________

**If you have more than one HIV test to request, you must list each date of each HIV test.*

This Authorization is made for the following purpose:

- ☐ At my request, OR
- ☐ Specify other reason(s): ____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on ☐ the one year anniversary of the date of my signature below, or ☐ the following date (insert date): ____________________.
2. I may revoke this Authorization at any time by notifying Planned Parenthood Orange and San Bernardino Counties in writing, and it will be effective on the date notified except to the extent that Planned Parenthood Orange and San Bernardino County 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.

SIGNATURE OF PATIENT ______________________________ **DATE** __________

FOR OFFICE USE ONLY

DATE OF REQUEST : ____________ **BY (print staff name) :** ______________________________

BY (print manager name): ______________________________

PATIENT ID PRESENTED: ____________________________

TYPE OF ID: ______________________________