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

Phone: 410-576-1414
FAX: 877-346-0108
Email: medicalrecords@ppm.care

AUTHORIZATION FORM TO RELEASE OR OBTAIN HEALTH INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____/_____/_____ LAST 4 DIGITS SS#: _____ MEDICAL RECORD #: _____

ADDRESS: _____ CITY: _____ STATE: ___ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

Release of information:

I authorize (choose one):

❑ Planned Parenthood of Maryland

❑ Other facility name: _____

to release information concerning medical records and/or treatment of the above-named patient to (choose one):

❑ Planned Parenthood of Maryland
Medical Records
330 North Howard Street
Baltimore, MD 21201
F: 877-346-0108
Email: medicalrecords@ppm.care

❑ Other:
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

For the following purpose:

❑ At my request
❑ Insurance
❑ Continuance of care
❑ Legal
❑ Other: _____

I request the information to be disclosed via (choose one):

❑ MyChart (only applicable if enrolled in MyChart)
❑ Fax
❑ Unsecured email (see disclaimer below)
❑ Mail
❑ In-person pick-up

Health information to be released:

DATE(S) OF CARE:

❑ Entire Medical Record, OR (check the appropriate box(es)) _____
❑ History and physical exam _____
❑ Substance abuse (including alcohol/drug abuse) _____
❑ Lab reports / Radiology reports _____
❑ Mental health (including psychotherapy notes) _____
❑ HIV related information (AIDS related testing) _____
❑ Other: _____ _____

CONDITIONS OF AUTHORIZATION:

1. This authorization will expire one year from signature date below unless specific expiration date or condition is named here:
   _____
2. I may revoke this Authorization at any time by notifying Planned Parenthood of Maryland in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Maryland 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.
6. Unsecured email disclaimer: Communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information included in emails can be intercepted and read by other parties besides the person to whom it is addressed.

X_____ OR _____

Patient Signature Date Parent/Legal Guardian/Authorized Person Date