Planned Parenthood®
Orange and San Bernardino Counties

Planned Parenthood/Orange and San Bernardino Counties, Inc.
Corporate Offices
Attention: Medical Records Clerk
801 E. Katella Avenue
Anaheim, CA 92805
714-633-6373 (Main)

REQUEST FOR COPY OF/AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

DOB: _____ SSN: _____ MR#: _____

Patient Address: _____

_____

Phone Number: _____

TO REQUEST RECORDS FROM PPOSBC

❑ **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 REQUEST RECORDS FROM ANOTHER HEALTH CARE PROVIDER

❑ **I HEREBY AUTHORIZE (PROVIDER):** _____

ADDRESS: _____

CITY: _____ STATE: ___ ZIP: _____

PHONE: _____ FAX: _____

To release my health information to:
Planned Parenthood/Orange and San Bernardino Counties
Attention: Medical Records Clerk
801 E. Katella Ave.
Anaheim, CA 92805

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	_____
❑	Lab reports (please specify which Lab report)	_____
❑	***HIV related information (AIDS related testing)**	_____
❑	Mental/behavioral health records	_____
❑	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.*

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I request my medical records to be sent in the following format:

☐ Paper copies **mailed** to:

☐ Same address as above

☐ Different address: _____

_____

_____

☐ **E-mail*** (encrypted) to the following email address:

_____

*Please be advised that there are risks of using e-mail to transmit your health records. E-mail may not be reliable, secure, or private. Among other risks, e-mail can be hacked, sent to the wrong person, and anyone with access to an email account will have access to all messages in that account. By requesting that your information be sent to you or another person via e-mail, you acknowledge and agree to the risks of transmitting and receiving your information by email.

☐ **Fax** to the following fax number: _____

☐ **Other**: _____

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.

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

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: _____