Planned Parenthood®
Planned Parenthood North Central States–PPMNS

RELEASE OF INFORMATION TO
PLANNED PARENTHOOD
NORTH CENTRAL STATES-PPMNS

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

PREFERRED NAME (if different from legal name): _____

DATE OF BIRTH: _____ PHONE: _____

Please be sure to fill in all information requested within this form. Doing so will ensure a swift release of records.
Please allow up to 7 business days for your request to be processed.

I HEREBY AUTHORIZE TO RELEASE MY HEALTH INFORMATION

FROM: Name: (Person or Organization)			**TO**: Planned Parenthood North Central States-PPMNS Attention: Medical Records		
Address:			Address: 671 Vandalia Street		
City:	State:		City: Saint Paul	State: MN	ZIP: 55114
Phone:	Fax:		Phone: 651-389-2384	Fax: 651-696-5543	

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:

- ☐ History/Physical
- ☐ Clinic visit/Progress Note
- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ Laboratory/Pathology Results
- ☐ Medications
- ☐ Psychotherapy Records
- ☐ Billing Records
- ☐ Diagnostic Results
- ☐ Operation/Procedure
- ☐ Immunizations
- ☐ Entire Medical Record (charges may apply)
- ☐ 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 notifying Planned Parenthood North Central States-

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PPMNS in writing, and it will be effective on the date notified except to the extent that Planned Parenthood North Central States- 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. By signing this authorization, I release Planned Parenthood North Central States- PPMNS from any and all liability resulting from redisclosure by the recipient.
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: _____