Planned Parenthood®
Care. No matter what.
Planned Parenthood of Greater Washington and North Idaho
123 E. Indiana Ave, Spokane, WA 99207 1.866.904.7721

MEDICAL INFORMATION RELEASE FORM

_____ / _____ / _____ / _____/_____/_____
Patient's Last Name **First Name** **M. Initial** **Date of Birth**

_____
Other name(s) medical records may be under.

MAIL RECORDS TO: Medical Records Department, 123 E. Indiana Ave., Spokane, WA 99207

FAX RECORDS TO: 1.509.248.3644

FROM: _____ **TO:** _____

_____ _____

_____ _____

READ CAREFULLY

I understand my medical records may contain information regarding sexually transmitted diseases, including HIV/AIDS, and information regarding abortion services. Release of this information is voluntary and is protected by State Law. I hereby release Planned Parenthood of Greater Washington and North Idaho and its staff from all legal responsibility that may arise from the release of medical information hereby authorized. I authorize you to release the following information to the physician/clinic indicated above. I understand that I have the right to revoke or cancel this authorization, in writing, at any time.

☐ My CURRENT MEDICAL RECORD, including past history, testing or treatment for sexually transmitted diseases, drug or alcohol abuse, abortion, and/or mental illness, INCLUDING information pertaining to HIV testing and AIDS.

☐ My medical record, INCLUDING my past history, testing, and treatment for sexually transmitted diseases, drug or alcohol abuse, and/or mental illness, EXCEPT for information pertaining to HIV testing and AIDS and/or abortion.

☐ My medical record, BUT NOT information relating to my past history, testing or treatment for sexually transmitted diseases, drug or alcohol abuse, and/or mental illness, or information pertaining to HIV testing and AIDS and abortion.

☐ OTHER: _____

_____ _____/_____/_____
Signature *Date*

NAME:

DOB:

PPGWNI #:

VALID FOR 90 DAYS FROM DATE SIGNED.