CLINIC ADDRESS LABEL HERE

Planned Parenthood of Greater Ohio

PUT PATIENT LABEL HERE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(PLEASE PRINT)

PATIENT NAME:____ **DATE OF BIRTH:**__________________________

I, THE UNDERSIGNED, HEREBY AUTHORIZE PPGOH TO ____ **RELEASE** ____ **OBTAIN**

INFORMATION CONTAINED IN MY MEDICAL RECORD TO/FROM:

NAME OF HEALTH CARE PROVIDER:____

ADDRESS:____ **PHONE:**____________________________

____ **FAX:**_______________________________

The following information is needed for continuity of care:

❑ Pelvic Exam
❑ Breast Exam
❑ Pap/Pathology Results
❑ Record of Last Depo Injection
❑ Colposcopy Results
❑ Colposcopy exam notes/Plan of Care
❑ Procedure Notes
❑ Laboratory Tests____
❑ ____

CONDITIONS OF AUTHORIZATION

1. This Authorization is valid for ninety (90) days.
2. I may revoke this Authorization at any time by notifying Planned Parenthood in writing, and it will be effective on the date notified except to the extent that Planned Parenthood 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.

PATIENT SIGNATURE:____ **DATE:**______________________

WITNESS:____ **DATE:**______________________