Planned Parenthood®
Planned Parenthood North Central States–PPH

RELEASE OF INFORMATION TO SELF

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 am requesting access to ☐ ***inspect*** or ☐ ***obtain a copy*** of (check the box that applies) my health information held by Planned Parenthood North Central States-PPH as follows:

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, op/procedure reports, medication, immunizations, medical history)

OR to only release specific portions of your health information, indicate the categories to be released:

☐ Clinic visit/Progress notes
☐ Laboratory/Pathology results
☐ Medications
☐ Psychotherapy Records
☐ Diagnostic results
☐ Operative/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

Please provide the information in the following format:

☐ Paper copy Send to the following address: _____

☐ Electronic copy Send to the following e-mail address: _____

IF YOU WISH HEALTH INFORMATION TO BE SENT VIA E-MAIL, PLEASE READ THE INFORMATION AT THE END OF THIS FORM ON THE RISKS OF RECEIVING UNENCRYPTED E-MAIL.

CONDITIONS

1. **THIS REQUEST IS LIMITED BY LAW.** This request for access to inspect or obtain a copy of health information is subject to all of the limitations found at 45 C.F.R. 164.524.

2. **TIME FOR RESPONSE.** PPH has up to 30 days to respond or to extend the time for response for an additional 30 days.

3. **ACCESS FORMAT.** PPH will attempt to provide information in the format you wish, but we are not required to reformat information in a form that we do not generally use.

4. **TIME AND MANNER OF ACCESS**. If access to inspect is granted, we will schedule a time and place that is convenient for all parties. If access to obtain copies is granted, the information will be mailed. Additionally, if agreed to in advance, Planned Parenthood may provide you with a summary of the requested information instead of providing access to the information.

   Electronic copies: if your health information is maintained electronically, you may request an electronic copy. We will provide it in the format you request (for example, pdf, word file) if the information is readily reproducible in that format. If it is not, we will try to offer you the information in another electronic format. If we cannot offer an electronic format that is acceptable to you, we will provide you with the Health Information in paper copies.

   If you request, we will provide you electronic copies via e-mail, but this may not be a secure method of transmission. Please read the "**RISKS OF USING E-MAIL**" section below before having your records e-mailed.

5. **FEES.** If a copy of the information is requested, PPH may impose a reasonable fee that includes the cost of copying, postage, and preparing an explanation of your health information (if requested).

6. **DENIAL OF A REQUEST FOR ACCESS.** If a request for access is denied, in whole or in part, a written explanation will be provided that contains: a) An explanation of the basis of the denial; b) A statement of your review rights, if applicable; and c) A description of how you may complain to PPH or to the Secretary of Health and Human Services ("HHS").

7. **NO RIGHT TO ASK FOR A REVIEW OF A DENIAL.** There is no right to a review if PPH denies a request for access to: a) Any information described in paragraph 1 above; b) If PPH created the information while acting under the direction of a correctional institution; c) The information involves research that is in progress and denial of access was agreed to as part of your consent to participate in the research; or d) The information was obtained from a third party under a promise of confidentiality, and access would likely reveal the source of the information.

8. **RIGHT TO ASK FOR A REVIEW OF A DENIAL.** You may ask for a review if access to the requested information is likely to endanger the life or physical safety of the requestor or another person or if access to the requested information is likely to cause substantial harm to the requestor or a third person.

RISKS OF USING E-MAIL

E-mail may not be reliable, secure, or private. For example:

- E-mail can be hacked. (Unauthorized people can intercept it, alter it, or use it).
- E-mail can be sent to the wrong person, lost, or subject to other sending errors.
- E-mail may come from someone other than the named sender.
- E-mail is easier to fake than handwritten, signed papers.
- Anyone with access to an e-mail account will have access to all messages in that account.
- Anyone who gets or has access to an e-mail can read, forward, copy, delete, or change it. This includes those who have permission to use the e-mail account as well as those who don't.
- Any deleted e-mails can be found again.
- E-mail services have a right to save and check e-mail sent through their system.

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You should not receive your health information via e-mail if people who you don't want to view your medical information have access to your e-mail account.

If you still want your information to be sent by e-mail, your signature below acknowledges the risks of transmitting and receiving your information by e-mail, as disclosed above, and you agree to release and hold harmless Planned Parenthood from any liability that may result from using e-mail to communicate. This includes, but is not limited to, breaches of confidentiality or privacy that may come from using e-mail (except as required by law).

Patient's signature: _____ Date: _____

OR legally authorized representative's signature: _____ Date: _____