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

RELEASE OF INFORMATION

Client Name/ID/DOB (or affix label)	Other names medical records may be under:
______________________	______________________

Planned Parenthood of Greater Washington and North Idaho (PPGWNI)	**PPGWNI may ☐ Disclose ☐ Receive ☐ Exchange the protected health information indicated below with:**
Address: ______________________	Person or Facility: ______________________
______________________	Address: ______________________
Phone: ______________________	______________________
Fax: 1.509.248.3644	Phone: ______________________
Attn: Medical Records Department	Fax: ______________________

I authorize the release of **any and all of the following medical, mental health and/or substance use disorder information, as specified**, which may be contained in my records (Check all that apply) with the following date parameters:
☐ All Dates – or – Date Range: ________________________

☐ Behavioral Health Diagnoses ☐ Mental Health Assessment ☐ Treatment Plan Reviews ☐ Substance Use Disorder Assessments	☐ Current medical record, including past history, testing or treatment for sexually transmitted diseases, drug or alcohol abuse, abortion, and/or mental health 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: ____

I understand that my record may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or of sexually transmitted diseases. I give my specific authorization for these records to be disclosed. (RCW 70.24.105)	☐ Approve ☐ Deny

____ ________________
Signature Date

____ ________________
Witness Signature Date

VALID FOR 90 DAYS FROM DATE SIGNED