PLANNED PARENTHOOD OF THE ST LOUIS REGION & SOUTHWEST MISSOURI
AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT PRINTED NAME:

_____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ MEDICAL RECORD #: _____
MO DAY YR

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ E-MAIL: _____

DAY PHONE: _____ CELL PHONE:_____

I REQUEST MY MEDICAL RECORD BE PROVIDED:
__ Paper (hard copy) or electronically by email: Email address_____

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF THE ST. LOUIS REGION & SOUTHWEST MISSOURI TO:

☐ RELEASE/SEND MY HEALTH INFORMATION **TO THE FOLLOWING** DOCTOR OR MEDICAL PROVIDER**:**

NAME:_____PHONE:_____

ADDRESS:_____CITY: _____

STATE: _____ ZIP: _____ EMAIL_____

☐ REQUEST/GIVE MY HEALTH INFORMATION **FROM THE FOLLOWING** DOCTOR OR MEDICAL PROVIDER:

NAME:_____PHONE:_____

ADDRESS:_____CITY: _____

STATE: _____ ZIP: _____ EMAIL_____

SEND TO: PPSLRSWMO at:

☐ Central West End Health Center
Reproductive Health Services
4251 Forest Park Ave
St. Louis, MO 63108
314-531-7526
F: 314-531-9731

☐ South Grand Health Center
3401 South Grand
St. Louis, MO 63118
314-865-1850
F: 314-865-0535

☐ West County Health Center
#1 Stonegate Center
Manchester, MO 63088
636-431-0030
F: 636-431-0035

☐ St. Peters Health Center
208 Mid Rivers Mall Center
St. Peters, MO 63376
636-279-3339
F: 636-279-2236

☐ North County Health Center
2796-98 North Highway 67
St. Louis, MO 63033
314-921-4445
F: 314-921-5165

☐ Fairview Heights Health Center
Lake Land Square
4529 North Illinois
Belleville, IL 62226
618-277-6668
F: 618-234-5230

Planned Parenthood
Care. No matter what.

☐ Springfield Health Center
626 East Battlefield
Springfield, MO 65807
417-883-3800
F: 417-883-3994

☐ Joplin Health Center
710 Illinois Ave
Joplin, MO 64801
417-781-6500
F: 417-781-3660

HEALTH INFORMATION TO BE RELEASED:

I specifically authorize release of the following information indicated in the box(s) checked below:

I UNDERSTAND THAT THE MOST RECENT WILL BE SENT UNLESS I HAVE WRITTEN A SPECIFIC DATE(S) BELOW

		DATE(S)	
	☐ Summary of visit (history, exam, progress & visit notes)	_____	
	☐ Lab reports	_____	☐
	☐ Ultra Sound	_____	☐
☐	☐ HIV test results	_____	☐
☐	☐ STI (sexually transmitted infection) test results	_____	☐
☐	☐ Prescribed medication information	_____	☐
☐	☐ Other: _____	_____	

☐ Entire Medical Record *($30.00 fee for paper records)* _____

☐ I request this information to be forwarded electronically if the party can receive it that way
☐

This Request and Authorization is made for the following purpose:

___To share information between health care providers who plan to or already have initiated or continue my care.

____ Other—Specify reason _____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on (insert date or event, generally 6 months out) _____
2. I may revoke this Authorization at any time by notifying Planned Parenthood of the St. Louis Region & Southwest Missouri in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of the St. Louis Region & Southwest Missouri 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.
6. If this authorization is for Marketing, I have been informed that Planned Parenthood of St. Louis Region & Southwest Missouri: ___ will ___will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

_____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

FOR OFFICE USE ONLY
DATE REQUEST FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FORM OF IDENTIFICATION: _____