

Cedar Rapids Health Center
3425 1st Avenue SE, Suite 100
Cedar Rapids, Iowa 52402
Phone (319) 363-8572

Dubuque Health Center
1766 Central Avenue 321
Dubuque, Iowa 52001
Phone (563) 583-3320

Monticello Health Center
South Main Street
Monticello, Iowa 52310
Phone (319) 465-2999

**AUTHORIZATION FORM
TO OBTAIN HEALTH INFORMATION**

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

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

ADDRESS: _____ City: _____ State: _____ Zip: _____

DAY PHONE: _____ EVENING PHONE: _____

I HEREBY AUTHORIZE PP OF EAST CENTRAL IOWA TO OBTAIN MY HEALTH INFORMATION FROM:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

HEALTH INFORMATION TO BE OBTAINED:

I specifically authorize Planned Parenthood of East Central Iowa to obtain the following information:

- Entire Medical Record, OR (check the appropriate box(s)) _____
- History and physical exam _____
- Progress notes _____
- Substance abuse (including alcohol/drug abuse) _____
- Lab reports _____
- _____

- DATES: _____
- Mental health (including psychotherapy notes) _____
 - X-ray reports _____
 - HIV related information (AIDS related testing) _____
 - Other: _____

This Authorization is made for the following purpose:

- At my request, OR
- Specify: _____

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire on (insert date or event): _____
2. I may revoke this Authorization at any time by notifying PP of East Central Iowa in writing, and it will be effective on the date notified except to the extent that PP of East Central Iowa 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.

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

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