

PLANNED PARENTHOOD OF THE ST. LOUIS REGION  
4251 Forest Park Avenue, St. Louis, MO 63108  
314-531-7526

**AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION**  
(from a non-PPSLR office)

PATIENT NAME:

\_\_\_\_\_ LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ MEDICAL RECORD #: \_\_\_\_\_  
MO DAY YR

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

DAY PHONE: \_\_\_\_\_ EVENING PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ BEEPER: \_\_\_\_\_

I HEREBY AUTHORIZE

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

**TO RELEASE MY HEALTH INFORMATION TO: PLANNED PARENTHOOD OF THE ST. LOUIS REGION**

- |   |   |
|---|---|
| <input type="checkbox"/> West County Health Center<br>#1 Stonegate Center<br>Manchester, MO 63088<br>636-431-0030<br>Fax 636-431-0035                         | <input type="checkbox"/> Central West End Health Center<br>4251 Forest Park Avenue<br>St. Louis, MO 63108<br>314-531-7526<br>Fax 314-533-1586 |
| <input type="checkbox"/> Fairview Heights Health Center<br>Lakeland Square<br>4529 North Illinois<br>Belleville, IL 62226<br>618-277-6668<br>Fax 618-234-5230 | <input type="checkbox"/> North County Health Center<br>2796-98 North Highway 67<br>Florissant, MO 63033<br>314-921-4445<br>Fax 314-921-5165   |
| <input type="checkbox"/> South Grand Health Center<br>3401 South Grand<br>St. Louis, MO 63118<br>314-865-1850<br>Fax 314-865-0535                             | <input type="checkbox"/> St. Peters Health Center<br>208 Mid Rivers Mall Center<br>St. Peters, MO 63376<br>636-279-3339<br>Fax 636-279-2236   |

**HEALTH INFORMATION TO BE RELEASED:**

I specifically authorize release of the following information:

DATES:

- Entire Medical Record, OR (check the appropriate box(s)) \_\_\_\_\_
- History and physical exam \_\_\_\_\_
- Progress notes/interim notes \_\_\_\_\_
- Substance abuse (including alcohol/drug abuse) \_\_\_\_\_
- Lab reports \_\_\_\_\_
- Mental health (including psychotherapy notes) \_\_\_\_\_
- Ultra Sound \_\_\_\_\_
- HIV related information (AIDS related testing) \_\_\_\_\_
- STI (sexually transmitted infection information) \_\_\_\_\_
- Pharmacy \_\_\_\_\_
- Other: \_\_\_\_\_

This Authorization is made for the following purpose:

At my request, OR

Specify: \_\_\_\_\_

**CONDITIONS OF AUTHORIZATION**

1. This Authorization will expire approximately 6 months from date of signature: \_\_\_\_\_
2. I may revoke this Authorization at any time by notifying Planned Parenthood of the St. Louis Region in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of the St. Louis Region 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

FOR OFFICE USE ONLY	
DATE REQUEST FILLED: _____	BY: _____
IDENTIFICATION PRESENTED: _____	FORM OF IDENTIFICATION: _____