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

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

NAME:_____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

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.

I have been informed that Planned Parenthood of the St. Louis Region ❑ 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: _____