Planned Parenthood®
Care. No matter what.
Planned Parenthood of Illinois

☐ Aurora Health Center
3051 E. New York
St. Aurora, IL 60504
Tel. 630.585.0500

☐ Austin Health Center
5937 W. Chicago Ave.
Chicago, IL 60651
Tel. 773.287.2020

☐ Bloomington Health Center
1319 N. Veterans Pkwy
Bloomington, IL 61704
Tel. 309.827.4014

☐ Champaign Health Center
302 E. Stoughton St.
Champaign, IL 61820 Tel.
217.359.8022

☐ Decatur Health Center
3021 Oakland Ave.
Decatur, IL 62526
Tel. 217.877.6474

☐ Englewood Health Center
6059 S. Ashland Ave.
Chicago, IL 60636
Tel. 773.434.3700

☐ Loop Health Center 18
S. Michigan Ave.
Chicago, IL 60603 Tel.
312.592.6700

☐ Near North Health Center
1200 N. LaSalle St.
Chicago, IL 60610
Tel. 312.266.1033

☐ Flossmoor Health Center
19831 Governors Hwy
Flossmoor, IL 60422
Tel 708.960.0907

☐ Orland Park Health Center
14470 S. LaGrange Rd.#101
Orland Park, IL 60462
Tel. 708.349.2227

☐ Ottawa Health Center
612 Court St.
Ottawa, IL 61350
Tel. 815.433.4111

☐ Pekin Health Center
328 S 4th St
Pekin, IL 61554
Tel. 309.347.1274

☐ Peoria Health Center
2709 N Knoxville Peoria,
IL 61604 Tel.
309.681.0350

☐ Rogers Park Health
Center 6353 N. Broadway
St. Chicago, IL 60660
Tel. 773.973.3393

☐ Roseland Health Center
11250 S. Halsted St.
Chicago, IL 60628
Tel. 773.468.1600

☐ Springfield Health Center
601 Bruns Lane
Springfield, IL 62702
Tel. 217.546.1060

☐ Waukegan Health Center
1601 N. Lewis Ave.
Waukegan, IL 60085
Tel. 847.672.2237

☐ Wicker Park Health Center
1152 N Milwaukee Ave
Chicago, IL 60642
Tel. 773.252.2240

☐ Clinical Follow Up and Case
Management Department
3051 E. New York St
Aurora, IL 60504
Phone: 312-592-6897
Fax: 312-533-2845

Authorization Form for Release of Health Records and Information

PPIL Pt. #_____

I, _____, Date of birth _____,
I understand that the information in my health record may include information related to STD's, HIV/AIDS and it may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that this authorization is voluntary. I can refuse to sign this authorization. I understand that if I refuse to sign this authorization, the hospital may not refuse to treat me or refuse to submit claims for services to my health plan. I understand that I have a right to inspect and copy the information to be used or disclosed because of this authorization. I understand that once this information is received by the authorized person or organization, then it may be subject to re-disclosure and may no longer be protected by federal privacy laws. I hereby give consent for the release and exchange of information between Planned Parenthood of Illinois and the following person(s) and/or agencies:

Name of Person or Agency _____

Address _____

City, State, Zip _____

Phone #_____ Fax #_____

Please check what is to be transferred [TO / FROM] PPIL *(circle appropriate)*

- ❒ Please provide complete Medical Records
- ❒ Medical Records from last annual exam only. Date: _____
- ❒ Please provide information as follows:
  - ❒ Annual Gynelogical Records
  - ❒ Colposcopy/Cryotherapy/LEEP Records
  - ❒ Depo or other Contraceptive Records
  - ❒ Other:_____
  - ☐ PapSmearRecords
  - ❒ P.O.CReport
  - ❒ Lab Results

_____

_____

CONDITIONS OF AUTHORIZATION

This Authorization is good for one year. I understand that I may revoke this Authorization at any time by notifying Planned Parenthood of Illinois in writing, and it will be effective on the date notified except to the extent that Planned Parenthood of Illinois has already acted upon such Authorization. Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and is no longer protected by Federal privacy regulations. With this release of information, my healthcare and payment for my healthcare will not be affected if I do not sign this Authorization form. I have been offered a copy of this signed Authorization form.

Signature of patient _____ Date_____

Signature of witness_____ Date_____

FOR OFFICE USE ONLY

Date Request Filled: _____ By: _____

Form of Photo Identifcation Presented _____

Patient Name: _____

Phone Number: _____

Provider Name: _____

Fax Number: _____

Contacts:	**Date / Time**	**Initial**
Fax / Mail / TC		
Fax / Mail / TC		
Fax / Mail / TC		
Fax / Mail / TC		
Comments:		