Planned Parenthood
Care. No matter what.
Planned Parenthood of the St. Louis Region and Southwest Missouri and Affiliated Corporations

AUTHORIZATION FORM FOR RELEASE OF HEALTH INFORMATION

PATIENT PRINTED NAME:_____ Date of Birth:_____

I HEREBY AUTHORIZE PLANNED PARENTHOOD OF THE ST. LOUIS REGION TO RELEASE OR RETRIEVE MY HEALTH INFORMATION:

☐ **Release To Medical Provider:** Fax:_____
Name:_____ Phone:_____

Address/City/State/Zip:_____

☐ **Release From Medical Provider:** Fax:_____
Name:_____ Phone:_____

Address/City/State/Zip:_____

I specifically authorize release of the following information indicated in the box(s) checked below: I understand the most recent will be sent unless specific dates are listed.

	DATE(S)
☐ Summary of visit (history, exam, progress & visit notes)	_____
☐ Lab reports	_____
☐ Ultrasound reports	_____
☐ Operative reports	_____
☐ Other: _____	_____

I give PPSLR permission to access my electronic medical records from other health care entities/EHR systems: inclusive of documentation from clinician and hospital visits, radiologic images and reports, laboratory results, and any pathologic evaluation.

SEND TO: PPSLRSWMO ATTN: MEDICAL RECORDS
4251 Forest Park Ave. St. Louis, MO 63108
FAX: 618-202-4807

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire 6 months from the date of signature
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.

SIGNATURE OF PATIENT or Parent/Legal Guardian:_____ DATE:_____

FOR OFFICE USE ONLY

DATE REQUEST FILLED: _____ BY: _____