Planned Parenthood
Care. No matter what.
Planned Parenthood Great Rivers

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Fax: 618-202-4807
Email: medicalrecords@ppgr.org

Patient Name: _____ **Date of Birth**: _____

I authorize the use and disclosure of my health information as described below:

From the following health care provider:	**To the following health care provider:**
Name	☐ Planned Parenthood Great Rivers *or* Reproductive Health Services of Planned Parenthood Great Rivers
Street Address	
City, State, ZIP	
Telephone	**Telephone** MO: 314-531-7526 or IL: 618-277-6668
Fax	**Fax** 618-202-4807
Email	**Email** medicalrecords@ppgr.org

I specifically authorize release of the following information:
For the following treatment dates or period: _____
I understand the most recent will be sent unless specific dates are listed.

For the following specific information:

- ☐ Entire medical record
- ☐ Clinic visit/Progress notes
- ☐ Laboratory/Pathology results
- ☐ Medications
- ☐ Immunizations
- ☐ Operative/Procedure
- ☐ Immunizations
- ☐ Diagnostic results
- ☐ Other: _____

This Authorization is made for continuity of care purposes. Please disclose records electronically.

CONDITIONS OF AUTHORIZATION

1. This Authorization will expire 6 months from the date of signing.
2. I may revoke this Authorization at any time during the above period by notifying Planned Parenthood in writing, and it will take effect on the day the request is received, except where the health information has already been released.
3. Planned Parenthood may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.
4. I understand that 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.
5. I understand that I may have a copy of this signed Authorization form if I ask for one.

_____ _____

Signature of Patient *or* Authorized Representative **Date**