North Metro Midwives, P.A.

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Authorization for Release of Protected Health Information

Print patient's legal name: _____ Birth date: ____/_____/_____
Previous name(s): _____ Phone: _____

1. Please release my records from: (Who has your records? Please list the specific hospital and/or clinic.)
   Name: _____
   Phone:_____Fax:_____
   Address:_____City:_____State:_____ Zip:_____
2. Release the records marked below for this condition or date(s) of treatment: _____ (if blank, we will release 1 years' worth of most recent records.)
   □ Pertinent Clinic Record Set (office visit, lab/radiology, medications, immunizations)
   □ Immunization records
   □ X-ray/Radiology films/CDs
   □ Lab/Pathology reports X-ray/Radiology Reports
   □ Other (please specify): _____

3. Please release my records to: (Who needs your records? Where do you want the information sent?)

Name: _____
Phone:_____Fax:_____
Address:_____City:_____ State:_____ Zip:_____

4. Date needed by: _____

5. Purpose: □ Continuing care □ Insurance □ Personal use □ Disability □ Legal □ Other _____

6. I understand that:

Except for psychotherapy notes (not included in medical record), the release of records listed in Section 2 may include details of treatment for mental health, chemical dependency, sickle cell anemia, genetic conditions and AIDS/HIV. **If I have received treatment for any of these conditions, I do not want the following records released:**
_____

- If I change my mind, I may write to the address in Section 1 to stop the release of my records. This will not apply to records that have already been released.
- Once the records are released to the name above, the clinic or hospital releasing my records cannot prevent them from being shared with a third party. At that point, the records may no longer be protected by state and federal privacy laws.
- I approve the release of records for future visits, starting from the date I sign this form through: _____.
- There may be a fee for releasing these records.
- A photocopy of this completed, signed form is considered valid if not altered.
- If I do not sign this form, I will still get medical treatment, unless treatment is part of a research project
- This form expires one year after I sign it, or on _____, except in certain situations specified by law.

Date _____Time_____

Signature of patient or authorized person If authorized person_____
Print name and description of authority to sign for patient (may require proof) _____