A Sacred Journey MIDWIFERY SERVICES

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# Authorization for Release of Records

Patient Name:_____Date of Birth:_____

Address:_____Social Security #:_____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

**Name of Individual/Facility to Receive PHI**

_____
_____

**Address**

_____
_____

**Fax Number**

_____
_____

**Name of Individual/Facility to Disclose PHI**

**Address**

**Fax Number**

Information authorized for use or disclosure, or to be obtained:

- o All medical information concerning this patient.
- o Medical information of this patient compiled between _____ to _____.
- o Other_____
  _

This information will be obtained, used, or disclosed for the following purpose(s) only:

- o Continued Treatment
- o At the request of the patient or patient's representative
- o Other_____
  _

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Practices. Unless revoked or otherwise indicated, the automatic expiration date will be one year from the date of signature.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by this authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

- I have the right to inspect the health information to be released and I may refuse to sign this authorization.

I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus. I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____
_____

Signature of Patient Date