

Authorization to Release or Request Confidential Medical Information

I hereby authorize:

Facility name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

To release the following information from the health records of:

Name _____

Date of Birth ____/____/____ Phone(s) _____

Dates of Treatment: From _____ To _____

Information to be released (please check):

- Copy of complete health records (including all mental health, drug/alcohol, and STD information)
- Billing & payment information
- Lab results (specify) _____
- X-ray reports/film (specify) _____
- Other (specify) _____

Information is to be released to:

Highland Midwife Birth Services

Lorri Ellen Carr 509-250-2072
 Eudine Stevens 406-939-1960
 PO Box 800 (114 W Main St)
 Goldendale, WA 98620
Fax: 509-773-0511



This authorization is valid for 120 days from the date signed. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance to this consent. I also understand that my records are protected under the federal and state confidentiality regulations and cannot be discussed without my written consent unless otherwise provided for in the regulations.

Patient Signature _____ Date _____