

### 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 \_\_\_\_\_

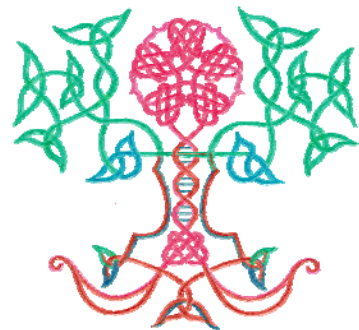
Information to be released (please check):

- Copy of complete health records (including mental health, STD's and drug/alcohol 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  
 Rebekah Pierson 509-547-4411  
 PO Box 800  
 Goldendale WA 98620  
**Fax: 509-772-2626**



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 \_\_\_\_\_