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 Phone: 509-314-1444
PO Box 800
Goldendale WA 98620
midwife@highlandmidwife.com
Fax: ☐ 509-772-2626 &/or **☐ 509-733-3041**

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 _____