

### 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ Day Phone(s) \_\_\_\_\_  
 Dates of Treatment: From \_\_\_\_\_ To \_\_\_\_\_

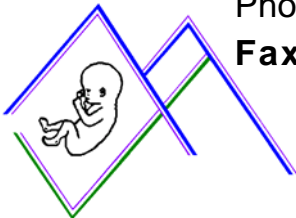
Information to be released (please check):

- Copy of complete health records
- Billing & payment information
- Lab results (specify) \_\_\_\_\_
- X-ray reports/film (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_

Information is to be released to (select one or both):

**Highland Midwife Birth Services**  
**Lorri Carr, LM CPM**  
**PO Box 800**  
**Goldendale, WA 98620**  
 Phone: 509-250-2072  
**Fax: 509-772-2626**

**Sunrise Midwifery**  
**Kristin Eggleston, LM CPM**  
**216 9<sup>th</sup> Street**  
**Prosser, WA 99350**  
 Phone: 509-780-3330  
**Fax: 866-359-8801**



This authorization is valid for sixty 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 \_\_\_\_\_