homebirth & women's health

WomanWise

Record Release

I hereby authorize disclosure of my individual health information as described below:
Client Name:_____ Date of Birth:_____ SS# _____
Mailing Address:

FROM: Name of Practice or Person: _____

Address and Phone: _____

TO: Name of Practice or Person: _____

Address and Phone:_____

The following information is to be disclosed: (check all that apply)

Physician Notes: yes____ no___ **Lab Results: yes_____ no____**

Ultrasound: yes____ no_____ **Complete Medical Records: yes___ no___**

All Obstetrical Records: yes___ no____ **Other (please specify): _____**

Additional Disclosures

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I authorize the release of this information YES____ NO____

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I also understand that I may inspect or obtain a copy of the information to be disclosed.

SIGNATURE OF CLIENT:_____ Date:_____