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Authorization of Release of Medical Records from AMFW

Patient's Name _____ DOB: _____

I authorize Allen Midwifery and Family Wellness to disclose information and records regarding my treatment, medical, and/or behavioral health condition(s) to _____

Phone of Facility _____ Fax _____

Please Include (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Physical Health Treatment Records |
| <input type="checkbox"/> Discharge and Summary | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Behavioral Health and Treatment Records | <input type="checkbox"/> HIV Records |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Genetic testing |
| <input type="checkbox"/> Ultrasound Reports | |
| <input type="checkbox"/> ALL OF THE ABOVE | <input type="checkbox"/> FOR THIS PREGNANCY ONLY |

The authorized purpose for this release is:

- | | | |
|--|---|---|
| <input type="checkbox"/> Diagnosis and Treatment | <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Transfer of Care |
|--|---|---|

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. This authorization is valid until I revoke it or for sixty (60) days after I have completed treatment, whichever is sooner, and I may revoke it at any time. This authorization was explained to me and I sign it of my own free will.

Client Signature: _____

Date: _____