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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"/> <b>ALL OF THE ABOVE</b>	<input type="checkbox"/> <b>FOR THIS PREGNANCY ONLY</b>

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
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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: \_\_\_\_\_