



**OPEN ARMS
MIDWIFERY, LLC**

408 S. Baldwin St, Madison, WI 53703
Ph: 608-469-1315 Fax: 888-521-2823

Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Maiden/Other Names: _____ Phone Number: _____

I authorize Open Arms Midwifery to release information TO:

AND/OR

I authorize Open Arms Midwifery to obtain information FROM:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone #/Fax # (Include area code)

Phone #/Fax # (Include area code)

TYPE OF RECORDS AUTHORIZED: Info necessary for further medical care Prenatal records
 Progress notes Immunizations
 Labs Ultrasounds
 Other _____

For the following dates: _____

Disclosure requiring Special Consent: *In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records related to the following: (select one or more as appropriate)*

Alcohol Treatment/Evaluation HIV test results Mental Health
 Drug Treatment/Evaluation Sexually Transmitted Infection Developmental Disabilities
 Other: _____

PURPOSE OF THIS REQUEST: (check one) Further medical Care Insurance Coverage Personal
 Other: _____

I authorize the one-time use or periodic use/disclosure use of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Open Arms Midwifery, LLC.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request Open Arms Midwifery, LLC except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires indication above under special consent.

Signature of Client/Legal Rep: _____ Date: _____

Relationship to Client (if requester is not the client): Parent Legal Guardian POA for Health Care