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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:

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:

One-time Use/Periodic Use/Disclosure: 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 the requested information has been sent/received, 90 days from this date, When I am no longer receiving services from Open Arms Midwifery, One year from this date, Other

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, 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