Authorization for Release of Protected Health Information

Client: _____ Date of Birth: _____ Phone : _____

I hereby authorize,

Provider:_____

Phone: _____ Fax:_____

to release the following health information for services dated _____ :

_____ Prenatal Records

_____ Postpartum Records

_____ Medical History/Physicals

_____ Ultrasound Reports

_____ Labs

_____ Surgical Reports

Please release all medical records to:

InJoyable Birth Midwifery

FAX: 480-418-3366

- I understand that my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse, etc.
- I recognize that I may revoke this consent at any time except to the extent that the information has already been released in reliance of this form. If not revoked, this consent will expire one year from the date signed.

Signature: _____ Date: _____