Authorization to Disclose Protected Health Information

I hereby authorize disclosure of my individual health information as described below:

Patient Name: ____________________ Date of Birth: __________ SS# ___________

Mailing Address: ____

FROM:

Name of Practice or Person: ____

Address and Phone: ____

TO: **Motherland Midwifery- Meredith Klein, CPM, Christy Santoro, CPM 1809 S. 16th St Philadelphia, PA 19145 Fax: 215-462-4785**

The following information is to be disclosed: (check all that apply)

Physician Notes ___ yes ___no

Ultrasounds ___ yes ___no

All Obstetrical Records ___yes ___no

Lab Results ___yes ___no

Complete Medical Record ___yes ___no

Other (please specify): _______________

Additional Disclosures

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

I authorize the release of this information ___YES ___NO

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I also understand that I may inspect or obtain a copy of the information to be disclosed.

SIGNATURE OF PATIENT: ________________________________ Date:___________