

River and Mountain Midwives
20 Calvin Blvd.
New Paltz, NY 12561
Phone: 845-256-5430
Fax: 888-566-2334

AUTHORIZATION FOR RIVER AND MOUNTAIN MIDWIVES TO USE MY HEALTH INFORMATION

Name: _____ **Date of Birth:** _____
Previous Name: _____ (if applicable)

PLEASE MAIL IF OVER 10 PAGES!

I. I authorize my health care information to be released from:

Name and organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Please disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following condition: _____
- Health care information in my medical record for the date(s): _____
- Other (ie, labs, ultrasounds) for the date(s): _____

You may also disclose the following information (check all that apply):

- HIV tests, diagnosis and treatment
- STI testing and information
- Psychiatric or mental health information
- Drug and/or alcohol treatment & tests

Please disclose the above information to River and Mountain Midwives at the above address or fax.

Reason(s) for this authorization (check all that apply):

- At my request
- For the practice marketing purposes
- Other (specify) _____

This authorization ends: (This document does not permit disclosure of health information more than 90 days after the date it is signed.)

- In 90 days from the date signed.
- On (date) _____
- When the following event occurs: _____

II. My Rights:

I understand I do have to sign this authorization in order to get health care treatment, payment or enrollment.

I may revoke this authorization in writing by writing a letter to *River and Mountain Midwives*. If I did revoke it, it would not affect any actions already taken by *River and Mountain Midwives* based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it.

Client or legally authorized individual signature

Date

Printed name if signed on behalf of the client

Relationship to client