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

AUTHORIZATION FOR RIVER & MOUNTAIN MIDWIVES TO ACCESS MY HEALTH RECORD

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