

Authorization to Release or Request Confidential Medical Information

I hereby authorize:

Facility name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

To release the following information from the health records of:

Name _____

Date of Birth ___/___/___ Day Phone(s) _____

Dates of Treatment: From _____ To _____

Information to be released (please check):

- Copy of complete health records
- Billing & payment information
- Lab results (specify) _____
- X-ray reports/film (specify) _____
- Other (specify) _____

Information is to be released to:



Sunrise Midwifery
PO Box 521 (mail)
1126 Meade Ave, Suite F
Prosser, WA 99350
 Contact: Kristin Eggleston
 Phone: 509-780-3330
Fax: 509-359-8801

This authorization is valid for sixty days from the date signed. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance to this consent. I also understand that my records are protected under the federal and state confidentiality regulations and cannot be discussed without my written consent unless otherwise provided for in the regulations.

Client Signature _____ Date _____

Note: Records containing information relating to drug, alcohol, mental health, HIV, and sexually transmitted disease testing, diagnosis, and treatment require a Special Authorization. Please see Page 2 of this form.



Special Authorization to Release or Request Confidential Medical Information

Special authorization for release of medical records is required for the following situations:

- Drug and Alcohol Abuse and Treatment Information
- Sexually Transmitted Disease, HIV Testing, Diagnosis, and/or Treatment Information
- Consent of a Minor (A Minor is anyone age 14 to 18 for Drug and Alcohol Abuse, Sexually Transmitted Disease, or HIV Testing, Diagnosis, and/or Treatment information, and age 13 to 18 for Mental Health information.)

Federal Regulations prohibit any further disclosure of this information except with specific written consent of the person to whom the information pertains or as otherwise permitted by federal law. A general authorization for the release of information is not sufficient for this purpose. A minor patient's signature is required in order to release information concerning care for: 1) conditions relating to the minor's sexuality including, but not limited to contraception, pregnancy and pregnancy termination, sterilization, HIV and sexually transmitted diseases; 2) alcoholism or drug abuse, and; 3) mental health conditions.

I hereby authorize:

Facility name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

To release the following protected information from the health records of:

Name _____

Date of Birth ___/___/___ Day Phone(s) _____

Date(s) of Treatment: From _____ To _____

Information to be released:

- Drug abuse diagnosis/treatment
- Alcoholism diagnosis/treatment
- Mental health diagnosis/treatment
- Sexually transmitted disease diagnosis/treatment
- HIV testing/diagnosis/treatment

Patient Signature _____ Date _____

Standard authorization should also be completed, see Page 1.