

Moonbelly Midwifery, LLC

**Mary Burgess, LM, CPM, MA**

360.510.0188 FAX to: 844-411-7474

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**Request for Release of Medical Information**

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_-\_\_\_-\_\_\_

I hereby Authorize my Healthcare Provider(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To release my protected health information as follows:

* Complete Medical Record for all services, including: History and Physical Exam, Progress Notes, Laboratory Tests, Physician Orders, Radiology Reports, Ultrasound and Inpatient Admissions
* HIV Test Results
* Records related to the following date(s) of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose of Request:

* Continuing Care
* Legal
* Insurance
* Patient Request for Use
* Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand the following (*Patient to Initial*):

\_\_\_\_\_ I understand that my records are protected under HIPAA regulations.

\_\_\_\_\_ I understand that under the Federal Protected Health Information regulations, I have the right to review my record and request amendments where appropriate.

\_\_\_\_\_ I understand that my health information may be subject to re-disclosure and not protected by Federal or State statutes.

\_\_\_\_\_ I understand that the specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals and/or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

\_\_\_\_\_ I understand that I may cancel this authorization at any time by submitting a *written* request to the address provided on this form, except where disclosure has already been made in reliance on my prior authorization.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release All Records Indicated to: Mary Burgess, Moonbelly Midwifery, LLC

3039 Peabody Street, Bellingham, WA 98225

Cell: 360-510.0188, **FAX: 844-411-7474**