

Moonbelly Midwifery, LLC

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

360.510.0188 FAX to: 844-411-7474

maryburgess555@gmail.com

**Request for Release of Medical Information**

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

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

I hereby Authorize: Mary Burgess, Moonbelly Midwifery, LLC

 3039 Peabody Street, Bellingham, WA 98225

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

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the following Healthcare Provider:

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Purpose of Request:

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

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

\_\_\_\_\_ I hereby authorize Mary Burgess, Moonbelly Midwifery, LLC, to disclose/release medical records and/or other information obtained in the course of my diagnosis and/or treatment.

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

\_\_\_\_\_ I agree to pay copy charges if applicable for Legal, Insurance and/or Personal Use.

\_\_\_\_\_ I hereby release Mary Burgess, Moonbelly Midwifery, LLC, from any liability which may result from this disclosure of confidential medical information, or which may arise as a result of the use of the information contained in the information released.

\_\_\_\_\_ 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. Unless withdrawn, this consent will expire 90 days from the date signed.

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