

Methow Midwifery & Women's Health
Blue Bradley, CNM, ARNP

PO Box 503
Twisp, WA 98856

Phone: 509-341-4256
Fax: 888-361-9674

AUTHORIZATION FOR METHOW MIDWIFERY & WOMEN'S HEALTH TO USE MY HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
Previous Name: _____

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
- STD testing and information
- Psychiatric or mental health information
- Drug and/or alcohol treatment & tests

Please disclose the above information to Methow Midwifery & Women's Health 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. However, I do have to sign this authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing by writing a letter to Methow Midwifery & Women's Health. If I did revoke it, it would not affect any actions already taken by Methow Midwifery & Women's Health 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.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship to patient