Authorization to Release or Request Confidential Medical Information

I hereby authorize:

Believe Midwifery Services, LLC
Penny Lane DNP, CNM, IBCLC
Kristina Michael MSN, CNM
118 West Main Street, Thorntown, Indiana 46071
(317) 434-2229 office phone
(317) 688-1080 office fax

To release the following information from the health records of:

Name _____
Date of Birth ____/____/_____ Day Phone _____
Dates of Treatment: From _____ To _____

Information to be released:

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

Information is to be released to:

Facility Name _____
Address _____
_____
Phone Number _____
Fax Number _____

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 _____

Witness Signature_____ Relationship _____