Snohomish Midwives
57 Cedar Avenue
Snohomish, WA 98290
877-869-6105
Fax: 360-563-2662

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ _____/_____/_____
PATIENT'S FULL NAME DATE OF BIRTH

**INFORMATION TO BE RELEASED BY:**
Organization:_____
Address:_____
_____
Phone:_____
Fax:_____

**INFORMATION TO BE RELEASED TO:**
**Snohomish Midwives**
**57 Cedar Avenue**
**Snohomish, WA 98290**
**PHONE: 877-869-6105**
**FAX: 360-563-2662**

**PURPOSE OF DISCLOSURE:**_____

I hereby request and authorize the release of the following information:
**GENERAL MEDICAL INFORMATION:**
Dates (From/To):_____/_____

☐ Clinic Records
☐ Hospital Records
☐ Lab Results
☐ Labor and Delivery Records
☐ Radiology/Ultrasound Reports
☐ All Healthcare Information In My Medical Record
☐ Health Care Information In My Medical Record Relating To The Following Treatment or Condition_____

_____ _____/_____/_____
Patient's Signature Date signed

**RELEASE REQUIRING SPECIFIC CONSENT:**
My initials and signature below authorize the release of healthcare information relating to testing, diagnosis, and/or treatment for:

_____HIV/AIDS
_____Sexually Transmitted Diseases
_____Mental Health
_____Alcohol/Drug Abuse

_____ _____/_____/_____
Patient's Signature Date signed

**Right To Revoke**
You may revoke this authorization at any time. Your revocation will not apply to any release we have already made in response to this authorization. To revoke this authorization, you must submit a written revocation to the clinic office at the following address:
Snohomish Midwives: 57 Cedar Ave, Snohomish, WA, 98290

**I understand that I have a right to revoke this authorization**

_____ _____/_____/_____
Patient's Signature Date signed

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility for benefits.

_____ _____/_____/_____
Patient's Signature Date signed

This consent form is valid for 1 year from date signed.