1 Mercado Street, Suite 145
Durango, CO 81301

Southwest Midwives

970-247-5543
Fax 970-247-5545
Toll Free 877-371-2011

PATIENT AUTOHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT: _____ _____
PLEASE PRINT NAME DATE OF BIRTH

By signing this authorization, I authorize Southwest Midwives to *receive*_____ *release*_____ certain protected health information (PHI) about me to/from the following provider, facility, or individual:

RECEIVED FROM/RELEASE TO: _____
Name of facility, provider, or individual

_____
Address City/State/Zip

_____ _____
Phone number Fax number

This authorization permits Southwest Midwives, or the above named facility, provider, or individual to use and/or disclose the following individually identifiable health information about me:

____All medical records ____Most recent annual exam report and findings
____Lab reports (specify if possible):_____
____Other (Please specify):_____

If information of the following is requested, it must be specifically checked and initialed by the patient:

____Mental health records ____ (pt. initial) ____HIV results/information ____ (pt. initial)
____Alcohol and drug dependency information ____ (pt. initial)

The information will be used/disclosed for the following purpose(s):

____Changing Providers ____Worker's Compensation
____Moving ____Legal Action
____Insurance Claim ____Referral
____At the request of individual/patient ___Other_____ (Please Specify)

The above purpose(s) is/are provided so that I/the patient can make an informed decision whether to allow release of the information. This authorization will expire 6 months from date signed. Only records generated in this office will be released.

A copy of this authorization *may*___ *may not*___ be used in lieu of the original.

I understand that I do not have to sign this authorization in order to receive treatment from Southwest Midwives. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Southwest Midwives has acted in reliance upon this authorization.

_____ _____
Signature of patient (or patient's authorized representative, or parent if minor) *Date of Signature*

_____
Relationship to Patient (parent, legal guardian, personal representative, etc.)

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Provider's Signature Authorizing Release (only if legal, mental health records, HIV records, alcohol and drug dependency records):

_____ Date records sent:_____Sent by:_____