

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

HIPAA Compliant Request for Information

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Name of Patient (Please Print)	Date of Birth (00/00/0000)	SSN
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Address	City	State	Zip Code
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I hereby give the following entity permission to release my Protected Health Information (PHI):

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Full name of entity	Address	City	State	Zip Code
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I instruct the above named entity to produce the following information:

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|--|--|--|
| <input type="checkbox"/> Complete Health Record                  | <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Abstract/Pertinent Info |
| <input type="checkbox"/> History and Physical Exam               | <input type="checkbox"/> Consultation Reports  | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Progress Notes                          | <input type="checkbox"/> Laboratory Tests      | <input type="checkbox"/> Radiology Reports       |
|  | <input type="checkbox"/> Emergency Dept Record |  |
| <input type="checkbox"/> Specified Date(s) of Service Only _____ |  |  |

HIV, Behavioral Health, or Drug and Alcohol Abuse/Treatment information contained within the dates of service I have specified above **are to be released through this authorization** unless specified below:

**DO NOT RELEASE:**     HIV             Behavioral Health     Drug/Alcohol

I authorize the above listed records to be released to:

**Westshore Midwifery Associates**  
**Colleen Brezine, CNM, Susan Dornan, CNM, Maureen Stein-Vavro, CNM,**  
**Sharon Johnson, CNM and Colleen Zelonis, CNM**  
**29101 Health Campus Drive, Building 2, Suite 250**  
**Westlake, OH 44145**  
**Phone: 440-827-5483    Fax: 440-827-5453**

At my request, my PHI is to be disclosed for the following purpose: \_\_\_\_\_

This authorization expires:     Ninety (90) days from signature     One (1) year from signature     One-time release

I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this Authorization as a condition to obtaining treatment, payment or eligibility for benefits. The information that I am requesting to be disclosed may be re-disclosed by the recipient and may no longer be protected by law. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

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Signature of Patient

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Date

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Signature of Parent/Guardian or Personal Representative (attach proper documentation)

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Date

**Copy:    Patient**  
**Medical Record of Patient**