AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize

Practice Name: _____

Obgyn/Midwife/MD name: _____

Address_____

Phone Number _____ Fax_____

To release the health information of the individual named below:

Client Name (Maiden): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number _____

Date of Birth: _____/_____/_____ SSN: _____

I authorize the information to be disclosed to and used by the following organization:

The Birth Center of Boulder
2800 Folsom Street
Boulder, CO 80304

Office: 303-443-3993
Fax: 303-442-4104

The type and amount of information to be disclosed is as follows (be specific):

_____

_____

_____

I understand that the medical information released by this authorization may include information related to the treatment of physical and mental illness, alcohol/drug abuse and medical history. I understand this authorization will expire without my express revocation, either one year from the date signed or if I am a minor, on the date I become an adult per state law. I understand that I may revoke this authorization in writing at any time. I understand that revocation will not apply to: (1) information already released by this request or (2) my insurance company to contest a claim under my policy or the policy itself. I understand that this authorization is voluntary and I can refuse to sign.

_____ _____

Signature of Client Date