MOUNTAIN MIDWIFERY CENTER, INC.
Compassionate. Experienced. Independent.

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Englewood, Colorado 80113
www.MountainMidwifery.com

RECORDS RELEASE & DISCLOSURE

Authorization for Mountain Midwifery Center, INC. to release protected health information for the purpose of:_____

Patient Name:_____

Date of Birth:_____

Phone Number:_____

Email: _____

Provider Name:_____

Address:_____

_____

Phone:_____

Fax:_____

◯ **Ultrasound:**_____

◯ **Labs:**_____

◯ **Genetic Screening:**_____

◯ **Health History:**_____

◯ **Pap Smear:**_____

◯ **Immunizations:**_____

◯ **All Records**

◯ **Current Pregnancy**

◯ **Other**

_____
_____

-I authorize the release of above information 1 year from signature date, unless noted otherwise. I understand I have the right to revoke disclosure of records, in writing to the address above, at any time. Revocation will not apply to information provided, accepted or retained in prior disclosures.

-I understand, unless the purpose of this authorization is to determine payment of a claim or benefits, MMC may not condition the provision of treatment or payment for my care on my signing of this authorization.

-I understand records released herein may include treatment of physical/mental illness, alcohol/drug abuse, communicable disease, and sensitive medical history.

-I accept full responsibility for copying fees. Per Colorado Department of Public Health & Environment regulation, the cost of copying records is $14.00 for the first 10 pages, $0.50 per page for 11-40, $0.33 per page 40+. Shipping fees also apply. ***There is no fee for sending records to another provider.***

X_____(patient)
X_____(authorized representative)_____(relationship to patient)

Date:_____