Labor of Love Midwifery, LLC
Release of Medical Information

Date:_____
I, _____, hereby authorize the release of the following information:
To include records dated from _____to _____.
Information to be released:

- History and Physical
- Laboratory Reports
- Ultrasound Reports
- Clinic Reports
- Gyn/Pap Reports
- OB SOAP Notes
- Discharge Summary
- Radiology Report/films
- Emergency Reports
- Pathology Reports
- Consultation
- Other_____

For the purpose of: (circle) Ongoing Care Ins. Claim Legal Request Personal Record Other

I acknowledge that the data to be released may include material that is protected by Federal Law. My initials and my signature below authorize the release of the following type of information:
____Drug/Alcohol Abuse information ____Mental Health information _____HIV information

From:_____ or **To_____:** **(please check appropriate action)**
Labor of Love Midwifery, LLC
1600 E Maradee Circle
Wasilla, AK 99654
Phone 907-841-2565
Fax 888-862-1422

From:_____ or **To_____:** **(please check appropriate action)**

_____

_____

_____

Phone(____)_____Fax(___)_____

Patient's identifying information:
Name of patient and time of tx:_____Birth Date:_____
SS#:_____Phone#:_____
Address at time of tx:_____

Signed:_____ Relationship to Patient _____

(Self, parent/guardian)

Initials_____Date_____

Witness:_____Date:_____

This consent will expire on _____ or 60 days after above date.