MIDWIVES OF NEW JERSEY
Serving Women, Honoring Birth.

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name_____ Date of Birth_____
Address _____
Telephone_____ SS# _____

## Information to be disclosed by mail or fax:

Complete Health Record
History & Physical Exam
Consultation Reports
X-ray Report
Progress Notes
Laboratory Tests (inc. HIV, STDs)
Other_____

| **Medical Records will be sent to:** | **Medical Records will be obtained from:** |
|---|---|
| **The Midwives of New Jersey, LLC** | |
| Provider Name | Provider Name |
| **PO Box 253** | |
| Address | Address |
| **Mt. Olive, NJ 07828** | |
| City/State/Zip | City/State/Zip |
| **908-509-1801** | |
| Phone # | Phone # |
| **732-301-9252** | |
| Fax # | Fax # |

Reason for disclosure:_____

This authorization will remain in effect for one year unless revoked by the client in writing and/or the midwife/client relationship is terminated. The client may revoke authorization at any time. The Midwives of New Jersey and its employees are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Client/Guardian Date