Client's Name _____ Date of Birth _____

Authorization to Protected Healthcare Information Request Form
The Midwife Center for Birth & Women's Health
2831 Penn Ave. Pittsburgh, PA 15222
Phone 412.321.6880 | Fax 412.321.7070
midwifecenter.org

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form to request access to or to receive a copy of your protected health information that The Midwife Center for Birth & Women's Health maintains regarding you.

I , _____, authorize The Midwife Center for Birth and Women's Health to (check all that apply):
☐ Allow me to inspect the requested records
☐ Provide a copy of the requested records to me
☐ Use the following protected health information
☐ Disclose the following protected health information to:

Name _____

Address _____

Phone/Fax _____

Description of records requested (please describe specific information and/or records requested and include time period):

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

_____

This authorization will expire on _____. I have the right to revoke this authorization in writing except to the extent that The Midwife Center for Birth and Women's Health has already acted upon this authorization. My written revocation must be submitted to the Operations Manager at the Midwife Center for Birth and Women's Health. I understand this information used or disclose as directed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by state or federal law. I do have to sign this authorization in order to receive care at The Midwife Center for Birth and Women's Health. In fact, I have the right to refuse to sign this authorization. I understand I have the right to inspect or copy the information to be used or disclosed. The use of disclosure requested under this authorization will result in direct or indirect remuneration to The Midwife Center for Birth and Women's Health from a third party (if applicable).

Client or Legal Guardian Signature _____ Date signed _____

Print Client Name _____

Print Name of Legal Guardian_____ Relationship to Patient _____

_____
For TMC Use Only: Identity of Individual or personal representative known/recognized? YES / NO

Request Approved. Request Denied. Response Delayed.

Comments _____

Signature of TMC Staff _____Date signed _____