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 RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize:

Name and Facility ____

Address ____

Phone/Fax ____

to release information for the record of:

Name ____ DOB ________________________ SSN ____________________

as described below to:

The Midwife Center for Birth & Women's Health
2831 Penn Ave. Pittsburgh, PA 15222
Phone 412.321.6880 | Fax 412.321.7070

Records are requested for the purpose of (PROVIDE A DETAILED DESCRIPTION):
☒ Continuing Treatment ☐ Second Opinion ☐ Other ____

Parts 1 and 2 must be completed to properly identify the records to be released.

1. Approximate date(s) of service: ______________________________

2. Specific information to be released (check all that apply):

☐ All prenatal records including labs, sonograms, and visit notes
☐ Pap smear results
☐ Emergency department report
☐ Lab results
☐ Ultrasound report
☐ Consultation report
☐ Mammography report
☐ Operative report
☐ Pathology report
☐ Medical history and physical exam
☐ Other; Please specify ____

HIV, MENTAL HEALTH AND DRUG & ALCOHOL information contained in the part of the records indicated above will be release through this authorization unless otherwise indicated.
Do not release: ☐ HIV ☐ Mental Health ☐ Drug & Alcohol

I understand this authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person. I authorized above to release the information. If applicable, specify other expiration date/event here: ____________________________________

Patient signature ____ Date signed ____________________
*14 years of age or older may authorize inpatient mental health information or 18 years of age or older for outpatient mental health information. A minor authorize release of drug & alcohol information.

Signature of Parent, Legal Guardian or Authorized Representative ____
Date signed ____________________
*Authorized representative relationship and authority to act on behalf of patient ______________________________

TMC Staff/Witness signature ____ Date signed ____________________

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT applicable to HIV related information or Drug & Alcohol treatment information
I witness that the patient understood the nature of this release. (Two witnesses are required)

Witness _____________________ Date _______________ Witness ______________________ Date _______________