BirthWise Maternity Care, LC
Heather Johnston, RN, LDEM
Janell Peterson, LDEM
360 South Fort Lane Ste 1-B
Layton, UT 84041
Office:(801) 928-9089
Fax: (801) 546-3207

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_____ Birth Date: _____ Phone # _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone:_____

Fax:_____

PLEASE SEND INFORMATION TO:

_BirthWise Maternity Care _____
Name of Provider/Clinic/Organization

_360 S Fort Ln Ste 1-B_____
Street Address

_Layton, _UT, 84041_____
City, State, Zip Code

Phone:__801-928-9089_____

Fax:__801-546-3207_____

RECORDS TO BE RELEASED (check all that apply)

_____ Entire Medical Record
_____ Specific Records Relating to Approximate Time Period of

_____ to _____
Date Date

_____ Records Pertaining to Ultrasounds
_____ Records Pertaining to Laboratory Results
_____ Records Pertaining to Pregnancy Date of Delivery:_____
_____ Records Pertaining to Cesarean Section

I hereby authorize the releasing facility to release the information indicated. I understand that my records are protected and cannot be disclosed without my permission. I understand that once my health care information is disclosed as I have authorized, it could be re-disclosed by the recipient and is no longer protected by the releasing facility. I also understand that there may be a change for making copies of records.

This Release of Records shall remain in force until revoked in writing.

Patient Signature_____ **Date**_____
If not patient, please note relationship to patient