



# Home Birth Midwifery Service™

Kim L. Mosny, CPM, LM

NARM CERTIFIED PROFESSIONAL MIDWIFE

Virginia Licensed Midwife

Cell: (901) 292-4876 • Office: (804) 651-0608 • FAX#: (888) 352-5879

Office Address: 13541 East Boundary Road • Suite 101 • Midlothian, VA 23112

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

### PLEASE OBTAIN INFORMATION FROM:

\_\_\_\_\_  
Name of Provider/Clinic/Organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Phone:

\_\_\_\_\_  
Fax:

### PLEASE SEND INFORMATION TO:

Home Birth Midwifery Service / Kim Mosny, CPM, LM

13541 E. Boundary Rd, Ste 101

Midlothian, VA 23112

Cell: (901) 292-4876

Fax: (888) 352-5879

I, \_\_\_\_\_, **AUTHORIZE** the following information to be disclosed: (Check  all that apply)

- Current Pregnancy Chart Notes
- Current Pregnancy Lab Report(s)
- Current Pregnancy Ultrasound Report(s)
- Past Pregnancy/Birth - Entire Record – Dates of Service: \_\_\_\_\_
- Past Pregnancy/Birth - Surgical Report(s) – Dates of Service: \_\_\_\_\_
- PAP Results – Date(s): \_\_\_\_\_
- Other: \_\_\_\_\_

**REASON for disclosure of health information:** (Check  and Initial)

- Personal Use \_\_\_\_\_
- Transferring Care \_\_\_\_\_
- Collaborative Care \_\_\_\_\_

### ADDITIONAL PATIENT INFORMATION:

\* I understand that I have the right to withdraw this authorization. To withdraw, please sign below.\*\*

\* I understand that I do not have to sign this authorization to get treatment.

\* I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

\_\_\_\_\_  
Patient Signature (Parent or Legal Representative, if applicable)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\*\* I wish to withdraw this authorization.

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY (Check & Date when completed)

- Pick Up Records
- Mail Records
- Fax Records

Date Completed: \_\_\_\_\_