MOONTOWER MIDWIFERY & WELLNESS
3600 W Parmer Ln Ste 108 Austin, TX 78727
Phone: 512-368-9370 Fax: 512-377-9300
Jessica Good, CNM ○ Emily Darnall, CNM ○ Bridget Kenny, CNM

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

We are unable to process incomplete forms. Please complete all areas.

Records Requested (pick one):

_____ Complete medical records.
_____ Records of care from ___/___/___(date) to ___/___/___ (date) only.
_____ Other (please specify) _____
_____ Confer with another person orally about information in my record. Specify person under "To"

I understand the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.

Please initial your choice below:

_____ Yes, I consent to the release of this information **_____** No, I do not consent to the release of this information.

Reason for Release:

I authorize the release of my health information for the following purpose:

_____ Patient request _____Insurance _____Disability
_____Referring Physician _____Other: _____

Requesting health information TO:

Provider/Clinic Name:	Moontower Midwifery and Wellness
Address:	3600 W. Parmer Lane Suite #108 Austin, TX 78727
Phone: **Fax:**	512-368-9370 512-377-9300

Provide health information FROM:

Provider/Clinic Name:	
Address:	
Phone: **Fax:**	

I, the undersigned, do hereby authorize the release of the information described above from my medical record. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Moontower Midwifery and Wellness. However, I understand that any action already taken on this authorization cannot be reversed and my revocation will not affect those documents. Unless otherwise specified, this authorization will expire in 1 year from today's date. I understand a reasonable amount of time, not to exceed 15 days, may be required to retrieve my records. The fee may be changed according to TMA guidelines. The maximum fee will be $25.00 for the first 25 pages and $0.25 for each additional page after 25 pages, for records requested by the patient (sent/given to the patient). There will be No Charge if records are sent directly to the Healthcare provider. REDISCLOSURE: I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

_____ _____
Patients full name (please print) Date of Birth

_____ _____
Patient Signature Date Signed