INDIAN CREEK
MIDWIFERY & BIRTH CENTER

Authorization to Release Confidential Medical Information

I hereby authorize:

Facility name _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

To release the following information from the health records of:

Name _____

Date of Birth _____/_____/_____ Phone _____

Dates of Treatment: From _____ To _____

Information to be released:

X Copy of complete health records

X Prenatal Records

X Lab results _____

X Imaging reports _____

☐ Other _____

Information is to be released to:

Indian Creek Midwifery & Birth Center, PLLC
132 Indian Creek Rd.
Ithaca, Ny 14850
Phone: 607-793-3792
Fax: 607- 821-4374 (please fax records)

This authorization is valid for sixty days from the date signed. I understand this consent can be revoked at any time to the extent that disclosure made in good faith has already occurred in reliance to this consent. I also understand that my records are protected under the federal and state confidentiality regulations and cannot be discussed without my written consent unless otherwise provided for in the regulations.

Client Signature _____ Date _____