Misty Ward, CPM * 540.830.4462 * Midwife@brookhavenbirth.com

Authorization to Disclose Health Information

Name:____________________________DOB:____________________Phone:__________________

Please release my healthcare information from:

Facility/Provider:______________________________

Address:____________________________________

City, State, Zip Code:___________________________

Phone:__________________Fax:_________________

Please send my healthcare information to:

Brookhaven Health and Natural Birth Center

Misty Ward, CPM

1461 Brookhaven Dr. Harrisonburg, VA 22801

Phone: (540) 830-4462/**Fax: (888)810-1461**

Information authorized to be released: (Please initial all that apply)
_____Current Pregnancy Chart Notes
_____Current Pregnancy Lab Report
_____Current Pregnancy Ultrasound Report
_____PAP Results
_____Past Pregnancy/Birth-Entire Record
_____Past Pregnancy Birth/Surgical Report

Purpose for which disclosure is being made: (Please initial)
_____Personal Use
_____Transferring Care
_____Collaborative Care

ADDITIONAL 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.

____ ___________________________

Client Signature Date

____ ___________________________

I wish to withdraw this authorization: Date