



Sacopee Valley Birthing Services

www.sacopeemidwives.org

Serving women in southern Maine and eastern New Hampshire.

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:

Date of Birth:

Previous Name:

Social Security #:

I request and authorize To release healthcare information of the patient named above to:

Name: Sacopee Midwives

Address: 11 River Rd

City: Limington

State: ME

Zip Code: 04049

Fax # 207 591 4767

This request and authorization applies to:

___ Healthcare information relating to the following treatment, condition, or dates:

___ All healthcare information

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes -simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquid Immunodeficiency Syndrome), and gonorrhea.

_ Yes _No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ date: