# Kona Birth & Midwifery Services

**Authorization to Release or Request Confidential Medical Information**

I hereby authorize:

Facility Name______________________________________________________
Address___________________________________________________________

Phone Number _____________________________________________________
Fax Number _______________________________________________________

to release the following information from the health records of:

Name ______________________________________

Date of Birth ____/____/______ Day Phone ____________________

Dates of Treatment: From ______________ To _______________________

Information to be released:

**Copy of complete health records**
**Lab results**
**X-ray reports/film**
**Other (specify):** All Prenatal Records and Ultrasounds

Information is to be released to:

Amy Kirbow, CPM
**PLEASE SEND FAX TO: 253-663-1626**
or mail to:
76-234 Kealoha Street Kailua-Kona HI 96740

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 federal and state confidentiality regulations and cannot be discussed without my written consent unless otherwise provided for in the regulations.

Client Signature _______________________________________ Date _____________

Witness Signature_______________________________________ Relationship _______

Midwife Signature_______________________________________ Date______________

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