Arizona Midwife, LLC
Alicia Witt, LM, CPM
602-midwife (643-9433)
fax to 480-247-4344
alicia@arizonamidwife.com

Records Release

Patient Last Name _____ First Name _____ Middle Initial _____

Phone Number _____ Date of Birth ____/____/____ SSN _____-_____-_____

I Hereby Authorize My Health Care Provider(s) _____

Phone Number _____ Provider Fax Number _____

To release my protected health information as follows:

- ◯ Complete Medical Record for all services including: History and Physical Exam, Progress Notes, Laboratory Tests, Physician Orders, Radiology Reports, Ultrasound and Inpatient Admissions.
- ◯ HIV Test Results
- ◯ Records related to the following date(s) of service _____

I understand the following:

_____ I understand that my records are protected under HIPAA regulations

_____ I understand that under the Federal Protected Health Information regulations, I have the right to review my record and request amendments where appropriate.

_____ I understand that my health information may be subject to re-disclosure and not protected by Federal or State statutes.

_____ I understand that the specific information to be disclosed in my medical record may include information regarding drug or alcohol use, counseling referrals and/or treatment of acquired immune deficiency syndrome (AIDS) or related conditions.

Patient Signature: _____ Date _____

Release All Records Indicated to: Alicia L. Witt, Arizona Midwife LLC
5647 W. Brown St, Glendale, AZ 85302
Office: 602-643-9433, **FAX: 480-247-4344**