Donna C. Roosa, MS, CNM
JoAnn Yates, MS, CNM
Lisa Millstein, MSN, CNM
Kimberly Maher, MSN, CNM ,
Jennifer Krogstad, MSN, CNM
Grace Rice, MSN, CNM
Julie Wood, MSN, WHNP

25 Lindsley Drive, Suite 201-A | Morristown, NJ 07960
Phone: 973.998.7922 | Fax: 973.998.7925 | info@avalonmidwives.com | www.avalonmidwives.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: Date of Birth:

Social Security #:

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

Avalon – A Center for Women's Health
25 Lindsley Drive, Suite 201-A
Morristown, NJ 07960

This request and authorization applies to:

☑ Healthcare information relating to the following treatment, condition, or dates

Prenatal Record: Including last pap test, hardcopy of all lab work and ultrasound reports

☐ All healthcare information ☐ Other

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 (Acquired 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.

☑ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.