River Valley Birth Center

526 West Park Row St. Peter, MN 56082
Phone: 507-934-1565
Fax: 507-934-2327

Authorization to Request Health Information

I authorize River Valley Birth Center (RVBC) to receive records of patient below:

Client Name ____
Address ______________________________ City ______________ State _______ Zip_______
Phone ___________________________ Date of Birth _____________ SSN ________________

Send via: ▫ Fax / ▫ Paper Print Out
Send records to: River Valley Birth Center, 526 W. Park Row, St Peter, MN 56082 **FAX: 507-934-2327**

Records being requested from:

Clinic/hospital name: ____

Clinic/hospital address (street, city, state): ____

Phone number of clinic/hospital: ____

The type and amount of information to be released to/from RVBC is as follows *(specify dates where appropriate)*

- □ Entire prenatal record for current pregnancy
- □ Lab results past 2 years
- □ Imaging/Ultrasound reports past 2 years
- □ Records for hospitalization from date: _________ to: ________, including all records, procedure notes, lab results, and imaging records.
- □ Other ____

I understand that the medical information released by this authorization may include information related to the treatment of physical and mental illness, alcohol/drug abuse and medical history.

I understand this authorization will expire without my express revocation, either one year from the date signed or if I am a minor, on the date I become an adult per state law. I understand that I may revoke this authorization in writing at any time except to the extent for actions that were already taken per this request. I understand that revocation will not apply to information that has already been released as specified by this request or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign. RVBC cannon condition treatment except as otherwise permitted by law. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

____
Signature of Patient or Authorized Personal Representative *Date*

____
Personal Representative Name (PRINT) *Date*