AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, (printed name) hereby authorize Lifecycle Wellness and Birth Center to complete the information requested in:

_____
Name of Form

To: _____
Person or Organization to receive completed form

I understand that my medical records could contain information regarding HIV and hepatitis status, psychiatric or psychological diagnosis or treatment and drug or alcohol use.

I understand that my authorization shall remain valid from the date of my signature until 60 days thereafter. I understand that I may revoke this authorization by written request except to the extent that action has been taken in reliance thereon.

_____ _____
Signature of Client **Date**

_____ _____
Print Name **Date of Birth**

_____ _____
Signature, in lieu of client, of authorized person **Date of Authorization**

_____
Signature of person obtaining consent

918 COUNTY LINE ROAD, BRYN MAWR, PA 19010 (610)525-6086 FAX (610)525-1846

www.LifecycleWellness.org