Release of Records

Sun & Moon Lactation

Patient Name: ______________________________

Date of Birth:______________________________

ID or Medical Record ________________________

Address: ___________________________________

____

Tel:____

AUTHORIZATION I: I give permission to Sun and Moon Lactation to use and release to Recipient (pediatrician/pediatric specialist)
Name:____
___Address:____
______Phone:______________________________Fax:______________________

AUTHORIZATION II: I give permission to ________________________________ to use and release to Recipient listed below

Name: Nicole de Faymoreau/ Sun and Moon Lactation

Address: 4154 Piedmont Avenue, Unit 7, Oakland, CA, 94611

Phone: (510) 800-MILK Fax: (510) 848-4434 (please text or call (510) 800-MILK prior to faxing)

PURPOSE: The health information disclosed may only be used for the following purpose(s): Evaluating and managing the breastfeeding dyad.

____

INFORMATION TO BE RELEASED: All lactation records and all records to pertaining to lactation including hospital records, and growth charts.

A. Medical record all health information (e.g. POC, assessment, and infant weight); AND images

B. Mental health of Parent or Guardian(s) (e.g. notes on affect, appearance, and conversation for the purpose of referral)

E.
Other____

Parent/Guardian Initial:___

DURATION: This authorization is valid immediately and will be valid until___________________(give date). If I do not write in a date, it will expire twelve months from the date it was signed.

CANCELLATION: I understand that I have a right to cancel this authorization any time. A cancellation (1) must be in writing, (2) sent or given to the Health Information Management Department and 3) is effective when it is received by the department. A cancellation will not apply to actions already taken by Sun and Moon Lactation under this authorization. Verbal cancellation will be accepted for behavioral and medical records pursuant to WIC Section 5328. Call: 510-800-MILK.

CONDITIONS: I understand that treatment will not be based on my giving or refusing to give this authorization. I also understand that I may refuse to sign this authorization.

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

REDISCLOSURE: Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA), although information protected by 42 CFR Part 2 continues to be subject to that protection. In addition, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

____

Patient/Patient's Representative Signature

Date _________________________