Fruit of the Womb, LLC
Record Release

I hereby authorize disclosure of my individual health information as described below:

Client Name:_____ Date of Birth:_____ SS# _____
Mailing Address:

FROM: Name of Practice or Person: _____
Address and Phone: _____
Fax number_____

TO: Fruit of the Womb, LLC
5411 Mt. Gilead Rd.
Reisterstown, MD 21136
Phone: 240-997-5319 **Fax: 443-450-9121**

The following information is to be disclosed: (check all that apply)
Physician Notes: yes____ no___
Lab Results: yes_____ no____
Ultrasound: yes____ no_____
Complete Medical Records: yes___ no___
All Obstetrical Records: yes___ no____
Other (please specify): _____

Additional Disclosures Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.
I authorize the release of this information YES____ NO____

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I also understand that I may inspect or obtain a copy of the information to be disclosed.

SIGNATURE OF CLIENT:_____ Date:_____