



Authorization For Disclosure of Confidential Information and Records Release

I hereby authorize and request the following provider to furnish information from or a copy of my health records to:

BetterBirth, LLC
230 West 170 North
Orem, UT 84057
(801) 225-5668 (voice)
(801) 434-8704 (fax)

Provider Name

Provider Street Address

Provider City, State, Zip Code

Provider Phone (voice)

Provider Phone (fax)

Please send:

All obstetrical records
ALL SONO REPORTS
All lab reports including a **LAB REPORT** showing blood type.
(handwritten blood type on prenatal record is NOT SUFFICIENT)

I understand that this is a required consent and I must voluntarily and knowingly sign this authorization before any records may be released, and that I may refuse to sign, but in that event the records will not be released.

I further release the above-named provider from any liability arising from the release of information to the individual(s)/agency designated herein.

I agree that a photocopy or fax of this form may be used in lieu of the original.

Client Signature

Witness Signature

Client Name: _____

Date: _____

Address: _____

Birth Date: _____

Phone: _____