NARM
North American Registry of Midwives

NARM Authorization for Release of Medical Records

This form must be filled out completely in black ink or typed.

Please fill out and submit a separate form for each care provider involved in the complaint.

I hereby authorize:

Midwife's or Doctor's Name: ______________________________

Address: ______________________________

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Phone: ______________________________

Email: ______________________________

to release any and all information regarding my health and care rendered to:

North American Registry of Midwives Accountability Committee
Directory of Accountability
888-842-4784 (phone/fax)
accountability@narm.org

This authorization includes the release of mental health records and drug and alcohol treatment records if included in my medical record—

❑ Yes ❑ No

This authorization includes the release of HIV related and AIDS related information and test results if included in my medical record—

❑ Yes ❑ No

Print Your Name: ______________________________ Birthdate: ______________

Address: ______________________________

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Phone: ______________________________

Email: ______________________________

I understand that these records will be used in NARM's Complaint Review and/or Grievance Mechanism. I understand that this consent may be revoked by me (in writing) at any time. A photocopy of this form may be used instead of the original.

Signature: ______________________________ Date: ______________

Please submit all Records Release Forms to the NARM Accountability Committee contact information above.