JAMII BIRTH & Wellness Services
2117 Smith Ave Suite F * Chesapeake, VA 23320
P: 833-JAMII4U (5264448) F: (757)859-0007

HIPPA Compliant Request for Information

Name of Patient (Please Print) _____ Date of Birth _____ SSN _____

Address _____ City _____ State _____

I hereby give the following entity permission to release my Protected Health Information **(PHI):**

Full Name of Entity _____ Address _____ City _____ State _____ Zip Code _____

I instruct the above named entity to produce the following information:

☐Complete Health Record ☐Discharge Summary ☐Abstract/Pertinent Info
☐History and Physical Exam ☐Consultation Reports ☐Radiology Reports
☐Progress Notes ☐Laboratory Test ☐Other
☐ Emergency Department Records ☐ Specified Date(s) of Service Only _____

HIV, Behavioral Health or Drug and Alcohol Abuse treatment information contained within the dates of service I have specified above *are to be released through this authorization* unless specified below:

DO NOT RELEASE: ☐ HIV ☐ Behavioral Health ☐ Drugs Alcohol

I authorized the above listed records to be released to**:**

Jamii Birth and Wellness Services
Nichole Wardlaw, CNM
3590 Towne Pointe Rd, Suite 6791
Portsmouth, VA 23703
Ph: 757-439-7406 Fax: 757-859-0007

At my request, my PHI is to be disclosed for the following purposes: _____

This authorization expires:

☐Ninety 90 days from signature ☐One (I) year from signature ☐One-time release

I may revoke this authorization at anytime by mailing are personally delivering a signed, written notice of revocation to the health care provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this authorization. I am entitled to a copy of this authorization upon my request. I may not be required to sign this authorization as a condition to obtain treatment, payment, or eligibility for benefits. The information that I am requesting to be disclosed maybe re-disclosed by the recipient and may no longer be protected by law. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____
Signature of Patient Date