



Tracey A. Bowman, CNM, ARNP  
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**HIPPA PRIVACY/RELEASE CONSENT FORM**

I consent to the use or disclosure of my protected health information by the Birth Cottage of Milford for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of the Birth Cottage of Milford and its midwives. I have been given a copy to read of the Notice of Privacy Practices as outlined under HIPAA law.

I give permission to the midwives at the Birth Cottage of Milford, LLC to provide my insurance company, obstetrics at the Cheshire Medical Center, and/or other consulting physicians and participating providers in my health care with copies of my maternity records as they see necessary in the course of my care with them.

I have received a copy of the Patient’s Bill of Rights and I understand my rights and responsibilities with regard to these.

I have the right to revoke this consent, in writing, at any time, except to the extent that Adrian E. Feldhusen, NHCM, CPM, Tracey A. Bowman, CNM, ARNP, or the Birth Cottage of Milford, LLC has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my care providers, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information my identify me.

I agree to ensure, to the best of my ability, that the Birth Cottage of Milford is paid in full for services rendered. If uninsured, I agree to pay for all services rendered, including all labwork. If insured, I agree to pay my deductibles, co-insurance, and co-payments after my insurance has paid their portion.

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date Signed