3127 Penn Avenue
Pittsburgh, PA 15201
info@midatlanticmilkbank.org
phone: 412-281-4400
fax: 412-281-4236

Permission to Request Donor Breastmilk and Related Health Information from Another Facility

Donor/patient name: _____ Birthdate: _____

Donor/child name: _____ Birthdate: _____

Name, address, and contact person at facility:

Name of hospital or facility: _____

Address: _____

_____

Contact name, email, and phone number: _____

_____

I authorize _____ (Health care facility) to release my breastmilk to the Mid-Atlantic Mothers' Milk Bank. I acknowledge and consent to the release of information that may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDs information which could impact my milk. I am aware that I may request a copy of this documentation.

_____ _____ _____

Donor signature Donor printed name Date

Mid-Atlantic Mothers' Milk Bank is a 501(c)(3) non-profit organization and all contributions made to the milk bank are tax deductible.

visit us at midatlanticmilkbank.org