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

Release of Donor Health and Breastmilk Information

Donor/patient name: _____ Donor birthdate: _____

Donor Number: _____

I AUTHORIZE:

Three Rivers Mothers' Milk Bank DBA Mid-Atlantic Mothers' Milk Bank to disclose:
(description of the health information on the patient identified above that is to be disclosed)

☐ Blood screening results

☐ All the medical records pertaining to the donor screening

☐ Other (specify): _____

_____

TO:

Name/Institution: _____

Street Address: _____

City, State Zip: _____

Fax Number: _____

FOR THE FOLLOWING PURPOSE:

☐ At the request of the individual

☐ To share milk with another HMBANA Milk Bank

☐ Other (specify): _____

_____

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NOTE: The purpose is not required if the disclosure is requested by the patient unless the disclosure concerns substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that any disclosure of health information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. **(NOTE: The recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.)**

I understand that I may revoke this authorization at any time except to the extent action has been taken in response to this authorization. I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Three Rivers Mothers' Milk Bank. (The written revocation must be legible and include the name and date of birth of the patient, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to the receive the information, the signature of the person with legal authority for authorization/revocation, and if not the patient, a description of their legal authority for authorization/revocation, and their phone number.)

Unless otherwise revoked, this authorization will expire:

☐ With donor retirement

☐ On the following date, event, or condition:

_____.

If I fail to specify an expiration date, event, or condition, this authorization will **expire in one (1) year**.

I certify that I am the patient, the patient's parent or legal guardian with the authority to authorize disclosure of this patient's protected health information.

_____	_____	_____
Donor signature	Donor printed name	Date