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Privacy and Information Disclosure

Please take a moment to read about your rights under the Health Insurance Portability and Accountability Act (HIPPA) and to affirm the following authorizations for disclosure of protected health information.

I understand that I have the right to:

- Request access to my health records at any time
- Request corrections be made to my health record
- Request that all communication regarding my care be restricted from unsecure transmission (fax, email, voice mail).
- Complain about perceived violation of my privacy to us, our licensing board, our certification board, or the US office for Civil Rights.

I agree to allow the photos that I share of myself, my family and my baby to be posted on my midwives personal website and Facebook page with identifiers such as first names, date of birth, birth location and weight.

- Website
- Facebook Page
- None

I agree to allow my midwife to use photos that I share for the purpose of education in presentation about midwifery and out of hospital birth.

- Yes
- No

Name: _____ Date: _____

Signature _____