Health Information And Placenta Release Form

Client Name ____

Address ____

______________________________Phone ________________

Due Date __________________Birth Date ____________________

Care Provider____

Birth Location____

I, ____________________________, request and acknowledge the release of the above named mother's placenta from the above named healthcare facility. I also, hereby authorize the following health information be released to Naturally Placenta, 470-822-9300 www.naturallyplacenta.com

Blood Borne Pathogen Tests (within 12months)

Healthcare Provider Must Complete This Section:

I hereby certify that____________________________has been tested for the following:

		Date of Test	Test Result
☐	HIV 1 and 2	________	________
☐	Hepatitis C	________	________
☐	Hepatitis B	________	________
☐	Other ____________	________	________

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Name of physician

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Signature of physician Date