CONFIRMATION/RELEASE STATEMENT

(To be completed if the woman selects a licensed certified nurse-midwife (CNM) or a licensed direct-entry midwife (DEM) to provide out-of-hospital services.)

THIS IS A LEGAL DOCUMENT WHICH AFFECTS YOUR LEGAL RIGHTS. YOU HAVE THE RIGHT TO AND SHOULD SEEK ADVICE OR COUNSEL FROM YOUR LEGAL REPRESENTATIVE PRIOR TO SIGNING THIS DOCUMENT.

If you select a midwife for out-of-hospital birthing services, it is your right and your responsibility:

(1) to inquire as to whether or not the midwife you have selected to provide pregnancy-related services has malpractice insurance; and

(2) to receive an informed consent or informed choice agreement regarding anticipated or unanticipated complications from the midwife that you have selected.

If the licensed certified nurse- midwife or licensed direct-entry midwife you have chosen does not have adequate or any malpractice insurance, you are assuming all risks of damage or injury that may occur by signing and submitting the following statement.

This signature also discharges the Health Care Authority, Medical Assistance Division (HCA/MAD), the Turquoise Care Managed Care Organizations (MCOs), and their employees from any and all claims, demands, and actions.

I am selecting _____ who, to the best of my knowledge,
(Name of Midwife)
is a NM Medicaid practitioner to provide pregnancy-related services that are necessary for my health and the health of my unborn child. If I am enrolled or become enrolled in a Turquoise Care Managed Care Organization (MCO), I understand that I am obligated to, and will follow the requirements of the MCO in accessing non-pregnancy related services.

I have reviewed the informed consent form that I received from the midwife whom I have selected to provide the out-of-hospital birthing services.

MEDICAL ASSISTANCE DIVISION | PO BOX 2348 – SANTA FE, NM 87504 | PHONE: (505) 827-3103 FAX: (505) 827-3185

In submitting this release to HCA/MAD and/or to the appropriate MCO, I hereby irrevocably waive, release and relinquish any and all claims that I or any person acting on my behalf may now or hereafter have against HCA/MAD and/or the MCO to which I am assigned to.

I have read, understand and agree to the content of this release.

_____ _____
Signature Date

_____ _____
Printed Name Date

_____
Address

_____
City, State, Zip Code

_____
Telephone Number

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