Western New York
Perinatal Bereavement Network

Authorization Release Form

The hospital where you have delivered is a participating member of the Western New York Perinatal Bereavement Network (WNYPBN), Inc. The mission of this Network is to assist the community to meet the needs of people facing the pain of perinatal death. We promote standards of bereavement intervention through educational support, community programs and referral services.

The WNYPBN has a number of support programs that may be beneficial to you in your time of loss. Please mark any/all of the programs in which you would like to participate, at NO COST to you.

- ❑ The quarterly newsletter called the "Forget-Me-Not," free of charge for one year following your loss. The newsletter is a forum for bereaved parents to share poems and stories, and to memorialize their babies.
- ❑ Information and notifications of up-coming events such as the annual "Walk to Remember," the annual "Evening to Remember" Basket Raffle, holiday services and various Network events.
- ❑ Parent Telephone Support Team (PTST) phone call. A parent with a loss similar to yours will call and speak with you about the many different emotions you may be experiencing.
- ❑ Sibling Program care package for young siblings in grief after the loss of your baby.

  Name & Age of Sibling(s): _____

  _____
- ❑ Funeral Assistance Information / Wings of Love Memorial Fund application and information.
- ❑ I do not wish to participate in any of these programs at this time.

I understand that my records are protected under the Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed without my consent. I may revoke this consent at any time by contacting the WNYPBN at 5780 Main Street, Williamsville, NY 14221. (716) 626-6363.

I understand that I can forward this information to the WNYPBN, or contact them at any time and they will gladly enroll me in the programs that I request.

Printed Name of Parent: _____

Signature of Parent: _____ Date: _____

Mailing Address: _____
(street) (city) (zip)

Phone Number: _____ email address: _____

Hospital of Delivery: _____ Delivery Date: _____

Type of Loss: _____ Baby Sex/Name: _____

Witness Name/Signature: _____