



Western New York  
Perinatal Bereavement Network, Inc.

**Authorization Release Form (HIPAA)**

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.

- Tiniest Angels Support Group In Person & Virtual groups available twice monthly.
- Parent To Parent A parent with a similar loss to yours, will call and speak with you about the many different emotions you may be experiencing.
- Sibling Program A care package for siblings, after the loss of the 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 The Wilson Support Center, 150 Bennett Road, Cheektowaga, NY 14227. (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:  Miscarriage  Stillbirth  Preterm Birth  SIDS  Other \_\_\_\_\_

Weeks Gestation: \_\_\_\_\_ Baby Sex/Name: \_\_\_\_\_

Witness Name/Signature: \_\_\_\_\_

**>>> HOSPITAL STAFF: PLEASE FAX ASAP TO 716-626-6368 <<<**