Request for Records

Patient Name: ______________________________ Date of Birth: ____________________

Patient Address:______________________________ Phone #: ________________________

To **SEND** Records:

I authorize Midwifery and Women's Health Care to **SEND** records to:

☐ Myself

☐ Mail Address:____

☐ Fax Number: ____________________

☐ I will pick them up (Call at this phone number when ready: ____________________)

☐ Provider or Practice: ____

Full Address: :____

Phone Number : ____________________ Fax. Number: ____________________

To **OBTAIN** Records:

I authorize Midwifery and Women's Health Care to **OBTAIN** records from:

Provider or Practice: ____

Full Address: :____

Phone Number : ____________________ Fax. Number: ____________________

Information you are requesting:

☐ Complete medical records

☐ Date range from ____________________ to ____________________

☐ Specific records: ____

I specifically authorize the release of:

☐ HIV/AIDS related test results ☐ Drug/alcohol diagnosis and treatment ☐ Mental health notes

I understand that I may cancel this authorization at any time by giving written notice to Midwifery and Women's Health Care. Unless canceled at an earlier date, this authorization will expire one year from the date of signing below, or on __________________.

Signature: ____ Date: __________________

Witness Signature: ____________________________________. Date: __________________

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