REQUEST FOR RECORDS

Patient____Birth Date________________________

Dates of Visits:____

IF YOU ARE NOT THE PATIENT:

What is your name?____

Your relationship to patient: ____

What gives you authority to receive the patient's information?

- □ Written patient authorization (please attach)
- □ You are the patient's parent or guardian (please attach evidence)
- □ You are the patient's healthcare decision maker (please attach evidence, such as POA)
- □ The patient is deceased, and you are the representative of the estate (please attach evidence)
- □ Other (please explain): ____

INFORMATION REQUESTED

Please mark the appropriate box to indicate the information to be released:

- □ Written medical records
- □ Summary of medical records (midwifery reports: summary, history and physical, etc)
- □ Bloodwork or other lab results
- □ Billing records

PURPOSE FOR REQUEST

- □ To obtain continuing care for patient. Please explain:____________________________________

  ____
- □ Other:____

METHOD OF DELIVERING INFORMATION

- □ I will pick up the records at the New Life Midwifery Office
- □ Please mail the records to me at____

I am authorized to receive copies of the medical and billing records for (insert patient's name) __________________________________. I understand that I may be charged for the postage, if requesting records to be mailed, and I agree to pay the total charges upon receipt of the copies.

____ ____________________

SIGNATURE OF PATIENT DATE

____ ____________________

SIGNATURE OF OTHER AUTHORIZED PERSON DATE