Back Cove Midwives
527 Ocean Avenue
Portland, Maine 04103
Phone 207-871-0666
Fax 207-347-7151

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient information:

Name: _____ D.O.B _____
Address: _____
_____

Phone (H) _____
(C) _____
(W) _____

I authorize _____to release my medical records to _____.

Particular records that I need are:

__Most recent physical
__Most recent labs
__Operative Note(s)
__Pathology report(s)
__Discharge Summary
__Obstetrical records
__Other_____

If they exist please DO or DO NOT include:

__Mental Health Records
__HIV Test Results
__Alcohol or Drug Records
__Other_____

I realize that refusal to disclose all or some healthcare information may result in improper diagnosis and/or treatment, denial of insurance coverage or other adverse consequences.

I know that I am entitled to a copy of this authorization form.

_____ _____
Patient Signature Date