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Beach Cities Midwifery and Women's Health Care

Fax

To: **From:** Beach Cities Midwifery & WHC

Fax: **Phone:**

Date: **Pages:**

Re: **Records Release** **CC:**

☐ **Urgent** □ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

Patient Name _____

SSN: _____ DOB: _____

I hereby authorize you to release to

_____

All records for

□ Current Prenatal care, laboratory results and ultrasounds pertaining to pregnancy, including physical exam, Pap smear and HIV testing, if performed.

□ Previous hospital record for delivery on _____

□ Complete medical records including gyn care including labs, pap smear, ultrasounds, mammogram, a physical exam, procedures, STI testing, including HIV testing, if performed

This release is good for one year from the date of the signing of this form.

_____
Patient Signature

_____ _____
Witness Patient Address

_____ _____
Date Patient Phone