The Birth Center: Holistic Women's Health Care LLC
1508 West 7th Street, Wilmington, DE 19805
Phone: 302-658-2229 Fax: 302-658-2382

I hereby authorize the office of:

Name: _____

Phone: Fax: _____

To disclose the following information:

____ Full medical records held by the above named office

____ Medical Records for the period _____ through _____

A specific portion/section of the record as follows:

_____

From the Medical Records of:

Name: _____

Date of Birth: _____ or Social Security: _____

For the purpose of:

_____

_____

I understand that unless earlier revoked, this request/authorization expires on _____/_____/_____ or upon receipt of the above requested records by the Birth Center. I may revoke this request/authorization in writing any time prior to the expiration date or receipt of records. I also understand that information from the requested records may be re-disclosed in the treatment or billing of my medical condition.

_____ _____

Signature: Date:

_____ _____

Print Name Relationship to Patient