

PATIENT RECORDS ACCESS REQUEST FORM
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 Birth Center to disclose the following information:

- _____ Full medical records held by The Birth Center
 - _____ 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:

To the office of:

Name:

Phone: _____ Fax: _____

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 transmission of records. I also understand that information from the transmitted records may be re-disclosed in the treatment or billing of my medical condition.

Signature:

Date:

Print Name

Relationship to Patient