The Birth Center: Holistic Women's Health Care LLC

620 Churchmans Road, Suite 101 Newark, DE 19702

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:

_____

For 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

_____ _____

Printed Name Relationship to Patient