Authorization for Release of Medical Records to

Corpus Christi Birth Center PLLC

Certified Professional Midwives

Client Information:

Print full name: _____ Date of Birth: _____

SS#: _____ Maiden or prior name: _____

This is a request for the following care provider:

Facility/Provider: _____

Address:_____

FAX Number: _____

Phone Number: _____

I authorize the release of my healthcare information to:

Corpus Christi Birth Center PLLC
939 Ayers Street
Corpus Christi, TX 78404
Phone Number: 361.883.2229
Fax Number: 661.457.1953

Information to be released - Any medical records that relate to my current pregnancy, birth or postpartum and newborn. (e.g. chart notes, labs, ultrasounds and special tests)

Other:

_____

_____

_____

Patient Authorization

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I specifically authorize the release all health care information relating to such diagnosis, testing or treatment. _____ (initial here)

Signature: _____ Date: _____