Authorization for Release of Medical Records

PATIENT NAME _____

BIRTHDAY _____ SS# _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

TELEPHONE _____

PREVIOUS ADDRESS (IF APPLICABLE)_____

CITY_____ STATE_____ ZIP_____

I would like my medical records released from the following physician/midwife/group:

Name of practice/hospital providing release of Medical Records:

Address: _____ City _____ State_____ Zip_____

Phone: _____ Fax: _____

Dates of Service Beginning: _____ To: _____

Sent to:
WomanKind Midwives
141 N. Eagle Creek Drive #200
Lexington, KY 40509
P 859.338.8268
F 859.263.8073

PLEASE RELEASE THE FOLLOWING RECORDS SELECTED BELOW

( ) Complete Medical Records
( ) Prenatal Records, including ultrasounds and labs
( ) Surgical Reports Date of Surgery _____ Type of Surgery_____
( ) Laboratory Results ( ) Pap Smear ( ) Biopsy Results
( ) Other

Signature_____Date_____