THE MIDWIFE GROUP
Women's Health & Birth Center

1692 CHATHAM PARKWAY SAVANNAH, GA 31405

PH: 912-629-6262 FAX: 912-226-3268

Authorization to Release Medical Information

Patient's name: _____

Date of Birth: _____ Date of request: _____

I authorize and request **The Midwife Group & Birth Center** to release a copy to:

_____

or to allow inspection of or copying of the complete medical records in their possession regarding my overall health care, illnesses, and any treatments rendered to me for the time period of:

_____ to _____.

I release above provider from all legal liability that may arise from this authorization.

Signature: _____ Date: _____

Address: _____

(P. O. Box, Route or Street) (City) (State) (Zip)

Witness: _____ Date: _____

If the signature above is not that of the patient, I am acting for the patient for the following reason:

_____

My relationship to the patient is: _____

Signed: _____ Date: _____