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: ______________________________ ________
(Practice Office Name) (Provider's Name)

______________________________ Fax #: ______________________
(City, State, Zip)
to release a copy of my medical record to:

The Midwife Group & Birth Center
1692 Chatham Parkway
Savannah, GA 31405
FAX: 912/226-3268

to allow inspection of my overall health care, illnesses, and any treatments rendered to me for the time period of

______________________ to ______________________.

Please include <u>ALL HARDCOPY</u> of Antepartum flow sheet, Health History and Physical, Visit Notes, Laboratory Results, Ultrasounds, and Reports.

I release the 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: ______________________

Rita Chesney, CNM, Director Cheryl Hartenbower, CNM Shelia Love, CNM

Stephanie Curtis, CNM Hannah Bergren, CNM Amanda Haddad, CNM

KAREN T. BAKER, MD, FACOG, MEDICAL DIRECTOR MARION MARSH, PHD, PSYCHOLOGIST