Women's Birth & Wellness Center
Claudine P. Calligan CNM, FNP-c

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

This will authorize our office to release the following medical information to the doctor you have listed below. Per HIPPA regulations this office will only provide the medical records of our treatments. This document is only good for thirty days and you have the right to revoke at any time in writing.

Please allow 5 to7 days for processing.

___ History & Physical ___ Pathology & Lab Reports ___ Hospital Summary
___ X-ray Reports ___ Office Summary ___ Pap Smear Report
___ Operative report ___ Other_____

Physician Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Date processed: _____ By Whom: _____

I understand that I may revoke this consent at any time and that, upon fulfillment of the above stated purpose this consent will expire in one year following the date of signature.