



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 to 7 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.

WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain personal information that is confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that dissemination, distribution, or copying of this information is strictly forbidden. If you have received this message in error, please notify us immediately and destroy this message.

** INCLUDING ALL ATTACHMENTS