



Medical Record Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/ person/ facility/ entity listed below.

Patient Name:

Date of Birth

The information you may release subject to this signed release form is as follows:

X Complete Records

- Radiology Reports/Operative Reports
- Pathology Reports
- Hospital Reports
- History & Physical
- Lab Reports

Release my protected health information to the following Physician/Person/Facility/Entity and/or those directly associated in my medical care:

Name: Happy Stork Midwifery Service

Address: 207 N Elkhart street, Wakarusa, IN 46573

Fax: (574) 393 9943

The Purpose/reason for this release of information is as follows:

_____ transfer of care_____

Signature: verbal permission from patient

Printed Name of Patient or Person Responsible