406 W Main St
Allen, TX 75013

p: 214-495-9911 f: 214-495-9918
info@allenmidwifery.com

Authorization of Release of Medical Records

Patient's Name _____ **DOB:**_____

I authorize the following physician_____at the following facility _____to disclose information and records regarding my treatment, medical, and/or behavioral health condition(s) to Allen Midwifery and Family Wellness.

Phone of Facility _____ Fax _____

Please Include (check all that apply)

- ☐ History and Physical
- ☐ Discharge and Summary
- ☐ Behavioral Health and Treatment Records
- ☐ Laboratory Reports
- ☐ Ultrasound Reports
- ☐ **ALL OF THE ABOVE**
- ☐ Physical Health Treatment Records
- ☐ Medication Records
- ☐ HIV Records
- ☐ Genetic testing
- ☐ **FOR THIS PREGNANCY ONLY**

The authorized purpose for this release is:

- ☐ Diagnosis and Treatment
- ☐ Coordination of Care
- ☐ Transfer of Care

I understand that my health and behavioral health records are protected from disclosure under Federal and/or state law. This authorization is valid until I revoke it or for sixty (60) days after I have completed treatment, whichever is sooner, and I may revoke it at any time. This authorization was explained to me and I sign it of my own free will.

Client Signature: Date: