Mother Blooming Birth Services & Midwifery

MEDICAL RECORDS RELEASE FORM

Patient Name: ____

Patient Address: ____

Home #: _________________ Work #: __________________ Cell # ______________

Birth Date: _________________________ Social Security No. ___________________

Please send a copy of my medical records:

TO: Adriann Walker LM, CPM
Mother Blooming Midwifery
PO Box 514 Monrovia, CA 91017
Fax 888-789-5484

FROM: _____________________________
____
____
(Office)_______________________
(Fax)_________________________

Please disclose the following information (check all that apply):

□ All healthcare information in my medical record

□ Healthcare information in my medical record relating to: __________________________

□ Health care information in my medical record for the date(s): ______________________

□ Other (ie, labs, ultrasounds) for the date(s) _____________________________________

You may also disclose the following information (check all that apply):

□ HIV tests, diagnosis and treatment □ STD testing and information

□ Psychiatric or mental health information □ Drug and/or alcohol treatment & tests

I understand that my medical records are protected under State and Federal confidentiality regulations. Disclosure of information regarding drug and/or alcohol abuse and treatment, confirmed sexually transmitted infections, including testing or treatment of HIV/AIDS and diagnosis of mental illness or psychiatric care cannot be released without my written consent. This consent can be revoked by me at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 180 days. I further authorize and request that you accept a faxed copy of this authorization as the original.

Signature ____ Date ____________

Witness ____ Date ____________

ADRIANN WALKER LM, CPM
P.O. BOX 514 MONROVIA, CA 91017
O 626-344-7874 F 888-789-5484

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