

Complete the following form and mail to the health care provider from whom you need records.
Be sure to make and save a copy of your request.

REQUEST FOR MEDICAL RECORDS

Your patient has requested that we obtain copies of her medical records from you.

Patient Information:

Full Name _____

Address _____

Date of Birth _____ Social Security Number _____

I, _____, authorize the release of
(print name)

- ALL MEDICAL RECORDS
 RECORDS DATED FROM _____ TO _____

by: _____
(Name of health care provider)

FAX # _____

To: **Midwifery Services of South Texas**
Claudine Crews, CPM, LM
204 Creekside Dr.
Floresville, TX 78114
830-393-0337 or FAX 830-393-3927 (please call prior to sending FAX)

- Permission is granted to send my records electronically (FAX)
 I prefer for my records to be mailed to the above address

Signature _____

Date of Request: _____