MIDWIFERY & WOMEN'S HEALTH CARE

Request for Records

All sections must be completed for the authorization to be valid.

Patient Name:_____ Date of Birth:_____

Address: _____ Phone No.: _____

The purpose of this disclosure is:

☐ Change of Provider ☐ Personal Use

☐ Referral/Continuation of Care ☐Other: _____

To SEND Records:

I authorize Midwifery & Women's Health Care to SEND/DISCLOSE records to:

☐ Myself

Please send records via:

☐ Email PDF ☐ Upload to Patient Portal ☐ Electronic Fax ☐ Paper (fee applies)

☐ Provider or Practice:_____

Full Address: _____

Phone No.: _____ Fax No.:Phone No.: _____

To OBTAIN Records from another Provider/Practice/Facility:

I authorize Midwifery & Women's Health Care to OBTAIN records from:

Provider or Practice:_____

Full Address: _____

Phone No.: _____ Fax No.:Phone No.: _____

Types of Information to be disclosed: RESTRICTIONS: Only medical records originating through THIS practice will be supplied.

☐	Complete Medical Records (last 3 years)	☐	Specific Date Range:_____ to _____
☐	Physical Therapy Notes	☐	Lab Results
☐	OTHER (Specify):		

I understand that under Alaska law, certain types of sensitive information require specific informed consent from the patient to be released. Your INITIALS ARE REQUIRED TO RELEASE THE FOLLOWING:

Mental Health Records		HIV/AIDS Related Results		Substance Abuse Records		Genetic Test Results	

I understand that I have the right to revoke this authorization by giving written notice. Unless revoked at an earlier date, this authorization expires 180 days from the date below.

Signature: _____ Date:_____