Northwest Women's Consultants, S.C.

OBSTETRICS•GYNECOLOGY•INFERTILITY

MEDICAL RECORDS REQUEST FORM

Name:____

Date of Birth:____

Phone number: ____

Please indicate the records you are requesting:

☐ My entire medical record

☐ Laboratory/x-ray reports

☐ Operative/surgical reports

Please indicate date(s) of surgery:_____________________________________

☐Other: ____

Please indicate below where you are requesting the records be sent.

Name: ____

Institution: ____

Address: ____

____

Phone number: ______________________ Fax number: ______________________

I, __________________________, authorize _______________________________ to release
(print your name) (name of office or doctor)
the above indicated records to the person/institution named above.

Signature: ____ Date: ___________________