CENTER FOR MATERNAL-FETAL CARE

1705 E. BROADWAY SUITE 300 COLUMBIA MO 65201
PH. 573-817-0810 FAX 573-817-1790

Consent to Release Medical Information

I hereby request that the following medical information be transferred

From:	**To:**
CENTER FOR MATERNAL FETAL CARE	_____
1705 E. BROADWAY, SUITE 300	_____
COLUMBIA, MO 65201-5852	_____
FAX: (573) 817-1790	Fax: _____
PHONE: (573) 817-0810	Phone: _____

Patient Name (list all names used in past):_____

Patient Birth Date: _____ Social Security No: _____

Patient Address: _____

Patient Phone Number(s): _____

I authorize the above doctor/practice to release information contained in my patient records, including, as applicable:

Information about communicable diseases and infections which may include sexually transmitted diseases, psychiatric notes, alcohol abuse, drug abuse, HIV test results, and AIDS or AIDS related disease diagnosis, unless otherwise specified here: _____.

Information Requested:

( ) All Records	( ) Discharge Summary	( ) Prenatal Records
( ) Labs	( ) History and Physical	( ) Operative/Pathology Reports
( ) Clinic Notes	( ) Ultrasound Reports	( ) All Fetal Testing Records

( ) Records related to the specific problem of:

_____
_____

Our Patient Privacy Policy is available on our website at www.fetalspecialist.com or you may request a copy be mailed to you.

I understand that this authorization shall be valid for one year unless otherwise specified or revoked by me through written notice and that such revocation would not be effective to the extent that the practice has relied on this authorization for its actions.

_____ _____
Signature of Patient Date