PATIENT RELEASE OF MEDICAL RECORDS REQUEST

I, (Patient's Name), _____ request and give my permission to release my Medical Records for the time period dating from_____ to _____ or any medical records that have been generated from the beginning of this pregnancy to the current date of _____ to:

North Jersey Midwifery Care, L.L.C.

Donna Tabas, CNM, M.S.

3196 Kennedy Blvd., Box 10

Union City, NJ 07087

Phone Number: 845-639-3098

Fax Number: 845-639-3159

I REQUEST THAT THE RECORDS BE FAXED TO 845-639-3159 IN ADDITION TO A HARD COPY BEING SENT TO THE ABOVE ADDRESS.

Printed Patient Name _____

Date of Birth_____Social Security #_____

Patient's Signature_____

Today's Date_____