Lifecycle
WELLNESS and BIRTH CENTER

Authorization to Release Medical Records From Lifecycle

Client name (Please Print): _____

Phone number: _____

Address: _____

_____

Date of Birth: _____ SSN _____

Please release my medical records pertaining to: _____

_____

For: □ Transfer of Care □ Physician/Medical Consult □ (other) _____

Please include the following confidential treatment information (check all to be included):

□ HIV/AIDS
□ Drug Abuse
□ Mental Health
□ Sexually Transmitted Diseases
□ Alcohol Abuse

(*Unless the above specific information is checked to be released, in most instances, it will be removed from the records being sent.)*

Time Period Requested: From Date:_____ to Date: _____

Send Records To: □ Me □ Physician/Medical Office

Please note that an electronic copy will be produced unless a paper copy is specifically requested below.

□ I am requesting a paper copy of my records and understand that LWC may charge me a reasonable cost for these copies, including postage costs if applicable, which I agree to pay.

Name of Physician/Practice: _____

Address: _____

Phone number: _____

Fax number: _____

Patient's Signature: _____ **Date:**_____

Please be advised that processing may take up to 30 days.