FINDLAY Women's Care™
OBSTETRICS | GYNECOLOGY | MIDWIFERY

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Medical Records Release Authorization Form

Due to copying & postage fees involved there will be a processing fee for records. Please see attached fee chart.

*Records to be sent to the office of:*____

____

*Reason for Transfer:*____

Please send the medical records of:

*Name:*____

*Address:*____

*City, State & Zip Code:*____

*Phone:*____

*Date of Birth:*____

*Previous Name:*____

*Records Requested:*____

*Patient Signature:*_____________________________*Date of Request:*_______________

*Records picked up by:*______________________________ *Date:*_______________

*Records mailed or faxed by:*__________________________ *Date:*_______________