WNC Birth Center
390 S. French Broad Ave
Asheville NC 28801
Office: 828.378.0075
Fax: 828.378.0083

Authorization for Release of Medical Records

Patient name _____

Date of Birth _____

I hereby authorize WNC Birth Center, to disclose my protected health information to:

Practice Name _____

Address_____

Phone _____

Fax_____

The specific information to be disclosed is: All prenatal records for current pregnancy including physical exam, copy of lab reports, ultrasound reports, prenatal flow sheets, and

_____

_____

_____

Beginning date _____ Ending date _____

I understand that I may revoke this authorization at any time by notifying the WNC Birth Center in writing my desire to revoke authorization
I understand that this authorization will become a part of my medical record with WNC Birth Center and that I have a right to a copy of this authorization any time.

Information about alcohol or substance abuse, HIV/AIDS, or mental health may be disclosed

☐ Yes ☐ No

Signature of Patient/Guardian: _____

Date _____

If signed by Guardian, relationship and description of authority to act for the patient

_____