Records Release Authorization

To: _____

(Doctor or Hospital)

_____

(Address)

I hereby authorize and request you to release to:

CBS Midwifery Inc.

80 Maiden Lane - Suite 901

NY, NY 10038

Office: 212-366-4699 Fax: 212-229-1020

the complete records, diagnoses, treatment, operative reports, laboratory reports, and follow-up, if indicated, pertaining to my care from _____ to _____

Name:_____ Date:_____

Address:_____

Signature:_____Witness_____

(If relative, state relationship)

Records/Chart number, if known:_____