# Prenatal Care Medical Release Form

## Patient Information

Full Name

Date of Birth

Address

Phone Number

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## Provider Information

Referring Provider/Clinic Name

Provider Phone Number

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## Release Authorization

I authorize the release of my medical records related to prenatal care to:

Address/Fax/Email of Receiving Party

Purpose of Release

Information to be Released

Special Instructions

## Expiration & Revocation

This authorization expires on

I understand that I may revoke this authorization at any time by providing written notice.

Patient Signature

Date