Aurora Family Health & Maternity Care Services, LLC
Aurora Birth Center

Authorization for Release of Records

Patient Name: _____

(Name of patient at time services were rendered)

Birthdate: _____ SS# _____

This form is to authorize that medical information regarding the above named person be forwarded **FROM:**

Physician / Institution

Street Address / Mailing Address

City / State / Zip

Phone Number: **Fax Number:**

TO:

Aurora Family Health & Maternity Care Services, LLC
21358 Hwy 99E
Aurora, Oregon 97002
Phone: (503) 678-6269
Fax: (503) 217-1599

Records Requested:

_____ History & Physical Exam ____ Diagnostic Tests & Labwork ____ Prenatal Records

Reason Requested:

_____ Transfer of Care ____ Continuation of Care _____ Other (Please specify)

Date_____

Signed (print) _____

Signature_____

(Signature of Patient or patient representative if minor)