



9489 Fosters Bend
Cleveland, TX 77328
FAX 281-825-5575
PHONE 832-777-0291

Dear Sir or Madam:

With reference to the client named below, please send a **complete copy of her records for current pregnancy** including history, physical assessment, lab work, sonogram results, diagnosis, and treatment. **If not a patient for the current pregnancy**, please send labor and delivery summary, **operative report** and postpartum summary for any cesarean sections you have record of. If neither of these apply, please send medical records as referenced: _____.

Thank you for your help.

Sincerely,

The Midwives of Wellspring Birth Center

Patient: _____

Address: _____

Patient's SSN: _____ - _____ - _____ Patient's DOB: ____/____/____

EDD: ____/____/____ (current pregnancy) – **or** – Baby's date of birth: ____/____/____ (previous pregnancy)

Authorization to furnish information

I authorize and request you to release to Wellspring Midwifery Care all information regarding examination and treatment, which I received while in your care, including copies of hospital and medical records.

Client Signature: _____ Date: ____/____/____