



289 Summer Street
Buffalo, New York 14222
(716) 885-2229
Fax: (716) 464-3361

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____

I, _____ hereby authorize you to furnish to Midwifery Services, Eileen Stewart, CNM, copies of medical records in your custody, pertaining to your care and treatment of me for OB/GYN care. Please fax or mail the record using the contact information above.

I was last seen at your office on _____.

Signature

Date