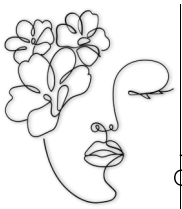

BLOOM

OBGYN AND MIDWIFERY CARE

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MEDICAL RECORD REQUEST

Please release a copy of my medical records from:

Doctor or Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

I authorize you to provide a copy of my medical records to:

Doctor or Facility Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____

Please release the following records:

_____ All Records Available
_____ Include all Sexually Transmitted Disease test results, psychiatric evaluations and drug/ alcohol abuse records.
_____ Do not send STD results, psychiatric evaluations or drug/ alcohol abuse records.
_____ All Records between the following dates: _____ and _____
_____ The following specific records: _____

_____

_____

Name: _____
DOB: _____
Signature: _____
Date: _____