Dar a Luz
BIRTH & HEALTH CENTER
7708 4th Street NW
Los Ranchos, NM 87017
P: 505.924.2229 F: 505.554.3673

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I _____ (DOB_____)

voluntarily authorize Provider_____

at Location_____ (phone: _____ fax: _____)

to release the following records to Dar a Luz Birth & Health Center:

**** Office staff will check which records are needed****

☐ **Obstetric Records for CURRENT pregnancy, including:**
- Ultrasounds
- Lab reports
- Prenatal history

☐ **Obstetric Records for PAST pregnancies, including:**
- Operative reports (if past C-section)
- Labor, delivery and postpartum summary
- Discharge Summary

☐ **Gynecology Records, including:**
- Pathology (including latest pap)
- Lab reports
- Medical histories

☐ **Other:**

I understand that my records may include information about behavioral or mental health services, drug and alcohol use/treatment, care for sexually transmitted diseases and/or the results of HIV tests.

I understand that I can revoke this at any time and must do so in writing. If I revoke this authorization, it will not apply to any information already obtained.

Please fax the medical file to **505-554-3673** as soon as possible.

Client signature Client name (please print)

Witness (DAL STAFF ONLY) Date