Willow Women and Children's Wellness, LLC
& Aurora Birth Center, LLC
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:**

Willow Women and Children's Wellness, LLC OR Aurora Birth Center, LLC
21348 Hwy 99E
Aurora, Oregon 97002
Phone: (503) 678-6269
Fax: (833) 963-2095

To The Following Provider/Group

____

Physician / Institution

____

Street Address / Mailing Address

____

City / State / Zip

____

Phone Number: **Fax Number:**

Records Requested:

_____ History & Physical Exam ____ Diagnostic Tests & Lab work ____ Prenatal Records

Date_____________________NAME (print) ____

Signature____

(Signature of Patient or patient representative if minor)