Perinatal Diagnostic Center, Inc.

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REQUEST FOR MEDICAL INFORMATION

Perinatal Diagnostic Center, Inc. is currently treating the patient identified below, and we are requesting that medical information for that patient be released to **Perinatal Diagnostic Center, Inc.** and forwarded to us at the above address.

Patient's Full Name: _____

Date of Birth: _____

Patient's Signature: _____ **Date:** _____

Information Requested: Perinatal Screening Results

I hereby authorize release of the above records to **Perinatal Diagnostic Center, Inc.**

OFFICE USE ONLY

Medical Information being requested from:

Facility: California Department of Public Health, Genetic Disease Screening Program

Or

Physician

Name: _____

Address: _____

City: _____ **Zip:** _____

Phone: _____ **Fax:** _____

Please return a copy of this form with the records. Thank you.