Consent to Transfer Records

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To:

Health Care Provider: _____

Phone/FAX: _____

From:

Client Name: _____

Date of Birth: _____

PHN: _____ Past Pregnancy: YES ____ NO ____

I, _____ am requesting midwifery care during this pregnancy and birth. Please fax a copy of all pertinent records (prenatal records, lab reports, ultrasounds, and birth summaries any previous pregnancies to the number listed above. I hereby authorize the release of my records as listed above to _____.

Signature: _____

Date: _____

If _____ is accepted into midwifery services, her maternity care will continue until the sixth week postpartum. At that time, copies of prenatal and/or birth records can be forwarded on request. In the event that concerns develop outside the scope of midwifery practice guidelines, consultation, or transfer of care will occur as set forth by the College of Midwives of British Columbia.

Thank you,

Jennifer Hewko, RM