

Placement Education Support Community

Record Release Authorization and Pregnancy Verification

Please have your doctor or clinic fill out the appropriate sections and then sign all three copies in the presence of your doctor or clinic. Return one copy to Pact, keep one for your records and leave one for your clinic or doctor. This form allows us to talk to your clinic or doctor about the medical aspects of the pregnancy and/or the medical condition of your child.

Patient's Name					
Doctor's Name					
Address					
Telephone					
Contact person					
Clinic Name					
Address					
Telephone					
Contact person					
Hospital Name					
Address					
Telephone					
Contact person					
Proof of Pregnancy					
Date this form was co	mpleted				_
Pregnancy has been ve	erified	yes	no		
Expected delivery date	e				
ı		r	nonth day	year	
					_
Authorized Signature (include title)					

Prenatal medical record release			
, hereby authorize the release of any			
all information and/or records relating to my car	re including history, diagnosis, reports,		
treatments, labs, or x-rays in your possession wh	hile a patient at your facility to Pact: An		
Adoption Alliance, the adoptive parents, and the	ne adoptive parents' physician.		
Patient's Signature	Date		
Child's Record Release Authorization			
I,name of birth parent	, being the parent of		
name of child as it appears on birth certificate	a minor child born on		
date and time of birth			
do hereby authorize the release of any and all of	the records relating to the care of said		
child, including history, diagnosis, reports, treat	ments, labs, or x-rays in your possession		
while a patient at your facility to Pact: An Ado	ption Alliance, the adoptive parents, and		
the adoptive parents' physician.			
Parent's Signature	 Date		