Authorization for Release of Medical Records

I hereby authorization my physician, _____,
to release my medical records to Dr. James G. Donahue.

_____ Entire chart _____ Operative Notes

_____ Admission Summary _____ Lab Results

_____ Discharge Summary _____ Social History

_____ Psychiatric Evaluation _____ IVF Flow Sheet and Embryo Lab Records

_____Other

Check one for the office you would like for your records to be sent to.

_____ Dr. James G. Donahue
5128 E. Stop 11 Rd.
Suite 38
Indianapolis, In 46237
317-865-0411 Phone
317-859-3815 Fax

_____ Dr. James G. Donahue
8435 Clearvista Pl.
Suite 104
Indianapolis, In 46256
317-595-3665 Phone
317-595-3666 Fax

_____ _____
Signature Date

_____
Print Name