

Authorization for Release of Medical Records

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

- | | |
|---|--|
| <input type="checkbox"/> Entire chart | <input type="checkbox"/> Operative Notes |
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Lab Results |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Other |

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

Dr. James G. Donahue
8051 S. Emerson Ave. #460
Indianapolis, In 46237
317-865-0411 Phone
317-859-3815 Fax

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

Signature

Date

Print Name