

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

\_\_\_\_\_ 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  
8340 Clearvista Pl. # 104  
Indianapolis, In 46256  
317-595-3665 Phone  
317-595-3666 Fax

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name