

## 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"/> IVF Flow Sheet and Embryo Lab Records |
| <input type="checkbox"/> 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