Authorization for Release of Medical Records

I hereby authorize my physician, ____________________________________
to release my medical records to Dr. James G. Donahue at Family Beginnings, PC.

_____ Entire chart

_____ Admission Summary

_____ Discharge Summary

_____ Psychiatric Evaluation

_____ Other

_____ Operative Notes

_____ Lab Results

_____ Social History

_____ IVF Flow Sheet/ Embryo Lab Records

Please send the records to:

Dr. James G. Donahue
8435 Clearvista Place, Suite 104
Indianapolis, IN 46256
Phone: (317)595-3665
Fax: (317)595-3666

________________________________ ______________
Signature Date

____
Print Name

Document Date: 9/3/2020