Authorization for Release of Medical Records

(Fill out the appropriate side of the form)

Records going TO Family Beginnings:

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

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

Records going OUT:

I hereby authorize Dr. James G. Donahue to release my medical records to:
_____

Please send the records to:

_____
_____
_____
Phone: _____
Fax: _____

Records Requested (check applicable):

_____ Entire chart
_____ Admission Summary
_____ Discharge Summary
_____ Psychiatric Evaluation
_____ Other

_____ Operative Notes
_____ Lab Results
_____ Social History
_____ IVF Flow Sheet/ Embryo Lab Records

_____ _____
Patient Signature Date

_____
Print Name

Document Date: 4/11/2022