

**Dr. Sarah Dutta and Betsy Aughenbaugh MSN, FNP-C**

107 N Regency Dr. Suite 3, Bloomington, IL 61701

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

**I hereby authorize:**

Dr. Sarah Dutta, OB-GYN, S.C  
Betsy Aughenbaugh MSN, FNP-C  
107 N Regency Dr. Suite 3, Bloomington, IL 61701  
P: 309-661-0406 F: 309-661-6446

**To disclose records to:**

Provider/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**To be released, check all that apply:**

*(please note the release will not include Genetic or HIV/AIDS information unless checked)*

Complete Chart     Genetic Information     HIV/AIDS Information     Labs     Pathology

Radiology     Consultation Reports     Immunizations

Records regarding specific treatment: \_\_\_\_\_

Other: \_\_\_\_\_

**\* I understand that this authorization is valid until it expires in 90 days**

**\* I understand that this authorization may be revoked at any time with written request**

Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_