

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:

Provider/Facility Name: _____

Address: _____

City/State/Zip Code: _____

Phone Number: (_____) _____

Fax Number: (_____) _____

To disclose records to:

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 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: ____ / ____ / ____