Dr. Sarah Dutta and Debra Gromley, APRN
107 N Regency Dr Suite 3
Bloomington, IL 61701
Authorization for Release of Medical Records

Patient Name: _____

Date of Birth: ___/___/___

Address: _____

_____

Phone Number: _____

Email: _____

I hereby authorize:
Provider/Facility Name:

_____

Address:

_____

City/State/Zip Code:

_____

Phone Number and Fax Number:

_____

To Disclose Records To: Dr. Sarah Dutta, OB-Gyn, S. C
Deb Gromley, APRN
107 N Regency Dr. Suite 3 Bloomington, IL 61701
P: 309-661-0406 F: 309-661-6446

To be released, check all that apply: (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