CONSENT FOR RELEASE OF PATIENT INFORMATION

I hereby authorize _____ to release
(name of doctor or medical facility)
medical information about the following person:

_____
Patient Name

Please send the information I have checked on the list below to:

Records to: **THE EINHAUS GROUP FOR WOMEN'S HEALTH**
10215 Auburn Park Drive
Ft. Wayne, IN 46825
Attn: Medical Records Manager
Phone 260-490-2229
Fax 260-490-3807

Information to be released:

___Discharge Summary
___History & Physical
___Surgery & Pathology Reports
___Laboratory Reports
___X-Ray Reports
___Emergency Treatment
___Entire Chart
___Other as Listed:_____
_____

Purpose of Release: _____

X_____ _____
Signature of Patient or Legal Representative Date

Patient Date of Birth: _____

Patient Address: _____

_____

Telephone Number: _____

** This form is for transferring records to The Einhaus Group and should be sent to the doctor or medical facility where your medical records currently reside. Your current provider may charge a fee for this service.