JASPER
OBSTETRICS & GYNECOLOGY
613 Dorbett St. • Jasper, IN 47546
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Jasperobgyn.com

I, _____ authorize and request the office of

_____

_____

_____

to release my medical records to

- ☐ Megan A. Isaacs, M.D.
- ☐ Jennifer M. Lueken, M.D.
- ☐ Farah R. Snyder, M.D.
- ☐ Kristin S. Werne, M.D.
- ☐ Lindsey J. Knepp, FNP-C
- ☐ Tara M. Knight, FNP-C
- ☐ Bethany J. Lubenow, PA-C
- ☐ Holly J. Zehr, FNP-C

___Records are needed for plan of care (URGENT) ___Records are needed for continuity of care

Records to be released and the dates treatment occurred:

[ ] All records: _____

[ ] Lab Work: _____

[ ] Pathology report: _____

[ ] Radiology report: _____

[ ] Operative report: _____

[ ] Other: _____

Purpose for release: _____

Patient Name _____ DOB _____

Patient Address _____

Patient Phone _____ SSN _____

This information is to be used for the purpose of further evaluation and treatment or for communication with other parties who are specifically named above. I understand that in order to obtain or release information, my consent is necessary. This consent is effective for 60 days from the date of signature. This consent may be revoked at any time by written or oral request of the person giving the consent.

Signature of Patient/Guardian _____ Date _____

Witness _____ Date _____