Release of Medical Chart Authorization Form

Name of Healthcare Provider/Physician: Dr.Tamzon D.Feeney,D.O.

Street Address: 2204 W. 58th St., Indianapolis, IN 46228

Patient Name: _____

Date of Birth: _____

I authorize and request the disclosure of all protected information. I expressly request that the designated record custodian above disclose full and complete protected medical information including the following: All medical records, meaning every page in my record. I understand that this will be my original chart and no copy will be retained by the physician.

Patient Signature:_____

Date: _____