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I, the undersigned, hereby authorize:

To release records to:

ALL MEDICAL RECORDS INCLUDING THE DIAGNOSIS, LABORATORY TESTS, AND EXAMINATIONS INCLUDING, BUT NOT LIMITED TO, INFORMATION REGARDING TREATMENT OF DRUG OR ALCOHOL ABUSE, PSYCHOLOGICAL CONDITIONS, HIV TESTING, OR AN AIDS RELATED CONDITION.

Date: _____ Witness: _____

Patient Signature: _____

Printed Name: _____ DOB: ____/____/____

Maiden or Previous Name: _____

Address: _____

Social Security Number: _____ - _____ - _____

Treatment Dates: _____

Purpose for Disclosure: _____

THIS CONSENT EXPIRES SIXTY (60) DAYS FROM THE DATE ORIGINALLY SIGNED.