DONOVAN

Authorization to FAX My Chart to Third Parties

PART 1. PATIENT CONTACT INFORMATION

PATIENT FIRST NAME: _____ PATIENT LAST NAME: _____

DATE OF BIRTH: (DAY/MONTH/YEAR) : _____ _____

PATIENT ADDRESS: _____

_____

PATIENT PHONE NUMBER: _____ EMAIL _____

PART 2: What do you consent us to fax?

☐ You have my consent to FAX my entire chart including blood tests and emails I have sent your office in the past
☐ You have my consent to FAX my entire chart but do NOT sent the email communications I have had with your office (keep that private)

PART 3: What is the EXACT name, address, fax or email address we are to mail or fax the documents?

EXACT NAME OF ORGANIZATION: _____

ADDRESS of ORGANIZATION: _____

_____

FAX NUMBERS: _____ EMAIL _____

PART 4. VERIFICATION OF REQUEST

I understand that there is a fee of $ 0.10 per page that is faxed. I understand that my documents will be faxed within 2 weeks of receiving this signed form from you. I understand that the information that is faxed could help, have no effect our hinder my receiving insurance or processing a claim either now or in the future. I understand that Dr. Donovan is acting in what he considers a honest and professional manner with full discloure

_____ _____

DATE (DAY/MONTH/YEAR) SIGNATURE

PART 5: CREDIT CARD BILLING INFORMATION

NAME ON CARD: _____

CREDIT CARD NUMBER _____

EXPIRY DATE: _____ 3 DIGIT CVV CODE _____