Ph: 317-536-4040 Fax: 317-344-0106

Vinay Belamkar, MD

Release of Medical Information

I, ________________________, request that ______________________ release the medical records of

Patient: ________________________

Date of Birth: __________________

Phone Number: _________________

TO:

Physician/Facility Name: Dr. Vinay Belamkar MD/Apollo Pain Center

Address: 3500 Depauw Blvd, Suite 2082

City/State: Indianapolis, IN 46268

Phone Number: 317-536-4040

Fax Number: 317-344-0106

Do you want *ALL MEDICAL RECORDS* released (check one)? ☐ Yes ☐ No

If you do not want all medical records released, please list records to be released:

____

____

How should we send records (check one)? ☐ Fax directly ☐ Pick-up in office

If you are requesting records to be printed and available for pick-up for your own keeping, a printing fee may apply. In that event, medical records staff will contact you prior to the medical records being printed to confirm payment arrangements.

Signature: ___________________________________ Date: ____________

Witness Signature: ___________________________________ Date: ____________