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: 2160 W. 86th St. Suite 202

City/State: Indianapolis, IN 46260

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: _____