

Pike Medical Consultants

6040 West 84th Street

Indianapolis, IN 46278

Office: 317-956-6288

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Pulmonary – Critical Care – Perioperative Medicine

The undersigned hereby requests the release of the following portion(s) of the medical record of:

(Patients full name and date of birth)

(Patient's address)

_____ Entire medical record

_____ The following specific portions of the medical record covering the dates mentioned:

To: _____

I understand that I may revoke this request at any time in writing, but the request shall remain valid until revoked or upon the expiration of sixty days (whichever occurs first).

(Patient, Parent, Guardian, Power of Attorney)
(circle one) *

(Witness)

(Address)

(Address)

(Phone number)

(Phone number)

(Date)

* If Guardian or Power of Attorney, copy of order must accompany this request.