

Medical Records Request



Lisa M. Holtsclaw D.O.
www.holtsclawmc.com

Note: You will be billed for chart copying as permitted by Indiana State Statute

4666 W Jefferson Blvd
Suite 140
Fort Wayne, IN 46804
Tel 260-432-0100
Fax 260-432-0117

Date: _____

I hereby authorize and request the release and transfer of information contained in the medical records of;

Full Name of Patient: _____

Date of Birth: _____ SS # _____

From: _____ concerning my illness treatment sent to

Purpose of the Release: _____

Type of Information to be requested: (check all that apply)

- FULL MEDICAL RECORDS or
- Discharge Summary
- History & Physical
- Consultation
- Surgery & Path Reports
- Laboratory Reports *
- X-Ray Reports
- Progress Notes

**This authorization specially covers any and all information relating to HIV testing and other AIDS diagnostic technique*

I, the undersigned, understand that I may revoke this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (6) days, whichever occurs first, EXCEPT to the extent that the action has been taken thereon. I understand that I am giving permission to release medical information which may include treatment or physical and/or emotional illness, communicable disease, alcohol or drug abuse treatment, and/or HIV, AIDS or AIDS-related information.

Witness

Signature of Patient or Legal Representative

Date

Address