AUTHORIZATION TO OBTAIN MEDICAL RECORDS

_____ _____

(NAME OF PATIENT) (DATE OF BIRTH)

The undersigned hereby authorizes _____

(Name of Organization)

to release my medical records and radiological studies to DAVID M. RATZMAN, M.D., and ANESTHESIA PAIN CONSULTANTS OF INDIANA for the purpose of my medical care. It is understood that this is confidential information and will be treated as such. This consent is subject to revocation at any time except to the extent that the above named entity has taken action in reliance on this consent. Unless otherwise revoked, this consent shall expire one year from the date below. I understand that the information used or disclosed may be subject to redisclosure by the person(s) or class of Person(s) receiving it and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

_____ _____

(SIGNATURE OF PATIENT) (DATE)

(RELATIONSHIP IF NOT PATIENT) _____

Please send the above records to: David M. Ratzman, M.D.
Anesthesia Pain Consultants of Indiana
8240 Naab Road, Suite 101
Indianapolis, IN 46260

Phone: 317-471-1400
Fax: 317-471-1900

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