# Authorization to Obtain/Release Medical Records

Patient Name:_____Patient DOB: _____

13225 N. Meridian St.
Carmel, IN 46032
Phone: (317) 228-7000
Fax: (317) 228-2321

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below:

Specific description of information to be used or disclosed:

All medical records
CD/Disc & Reports
Other: _____

How do you want to obtain the records?

Pick up in-person
Fax or Email: _____
Mail to address:_____

Please select physician:

| | | | |
|---|---|---|---|
| ☐ Brian Adams, M.D. | ☐ Robert Funk, M.D. | ☐ Paul Kraemer, M.D. | ☐ Ken Renkens, M.D. (retired) |
| ☐ Shah Ahmad, M.D. | ☐ Jonathan Gentile, M.D. | ☐ Kevin Macadaeg, M.D. | ☐ Dan Robinson, M.D. |
| ☐ John Arbuckle, M.D. | ☐ Erik Gerlach, M.D. | ☐ Ashwin Madupu, M.D | ☐ Rick Sasso, M.D. |
| ☐ Barrett Boody, M.D. | ☐ John Gorup, M.D. | ☐ Michael McCarthy, M.D. | ☐ Joseph D. Smucker, M.D. |
| ☐ Mario Brkaric, M.D. | ☐ Lori Kiefer, M.D. | ☐ Justin Miller, M.D. | ☐ Peter Swiatek, M.D. |
| ☐ John Chambers, M.D. | ☐ Daniel Kim, M.D. | ☐ Zachary NaPier, M.D. | ☐ Jose Vitto, M.D. |
| ☐ Neil Farren, M.D. | ☐ Jeff Konopka, M.D. | ☐ Tom Reilly, M.D. | ☐ Jason Ye, M.D. |

I authorize the following person(s) to use or disclose the above health information:

_____

I understand that I may revoke this authorization at any time by notifying Indiana Spine Group in writing. If I choose to do so, my revocation will not affect any actions taken by Indiana Spine Group before receiving my revocation.

I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires one year after signature date.

Patient Signature:_____Date: _____

Guardian Signature (if minor patient):_____Date: _____

Relationship to Patient: _____