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