# 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:

- ☐ John Arbuckle, M.D.
- ☐ Neil Farren, M.D.
- ☐ Daniel Kim, M.D.
- ☐ Kevin Macadaeg, M.D.
- ☐ Tom Reilly, M.D.
- ☐ Joseph D. Smucker, M.D.
- ☐ Barrett Boody, M.D.
- ☐ Robert Fund, M.D.
- ☐ Jeff Konopka
- ☐ Michael McCarthy, M.D.
- ☐ Ken Renkens, M.D. *(retired)*
- ☐ Jose' Vitto, M.D.
- ☐ John Chambers, M.D.
- ☐ Jonathan Gentile, M.D.
- ☐ Paul Kraemer, M.D.
- ☐ Justin Miller, M.D.
- ☐ Rick Sasso, M.D.

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

Person(s) receiving my authorization information include:

_____

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: _____