

# Indianapolis Neurosurgical Group

## Release of Medical Records

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_

I hereby voluntarily authorize and consent to disclosure of my health records and / or information as stated below. I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain services, treatment or payment for services; unless services provided are solely to create health records for a third party, such as physical and drug testing for an employer or insurance company; or if treatment provided is research related and authorization is required for the use of health information for research purposes.

I understand that I may see and copy the information described in this form if I ask for it.

Unless limited below, I understand that this release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR Part 2) or State Law (IC 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding treatment and related services for alcohol and / or substance abuse, communicable disease documentation, human immunodeficiency virus (HIV) or for mental health treatment or counseling.

I authorize the Indianapolis Neurosurgical Group to release information to: \_\_\_\_\_

I authorize the Indianapolis Neurosurgical Group, Inc to obtain information from: \_\_\_\_\_

The purpose or need for the disclosure: \_\_\_\_\_ At the request of the individual \_\_\_\_\_ Other (Specify) \_\_\_\_\_

Information to be disclosed (Dates of Service): \_\_\_\_\_

I understand that this authorization is voluntary and that I have the right to revoke it at any time prior to its expiration date by written notification to the Indianapolis Neurosurgical Group, Inc. This revocation will not have any effect on the information released pursuant to this Authorization before the revocation. I understand that the information released may be subject to redisclosure by any recipient and no longer protected by federal privacy laws.

Expiration Date or Event: \_\_\_\_\_

Information to be released: \_\_\_ Verbally \_\_\_ Photocopy \_\_\_ Faxed \_\_\_ Other \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent /Guardian / Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Authority of Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Copy of this Authorization Given to Patient. Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Records Released by: \_\_\_\_\_ Date: \_\_\_\_\_