

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_  
(Last) (First) (Initial) (Mo-Day-Yr)

I hereby authorize the physicians and/or authorized personnel of the Indianapolis Neurosurgical Group, Inc. to release any current reports or information acquired in the course of my examination or treatment by them to my family physician, referring physician(s), and other individuals or organizations as listed below. This authorization will remain in force for sixty (60) days from the date signed unless revoked by the undersigned in writing. (Indiana Code 16-4-8) (1-11)

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\_\_\_\_\_  
Name and Address of Organization

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(By Patient/Parent/Legal Guardian)\*

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

\*This authorization MUST be signed and dated by the PATIENT unless a minor, or patient has legal guardian; then parent or legal guardian must sign and date.

Updated Patient Authorization: \_\_\_\_\_  
Signature Date

Updated Patient Authorization: \_\_\_\_\_  
Signature Date

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Signature Date

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Signature Date

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Signature Date