

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

(Name Of Patient)

(Date Of Birth)

The undersigned hereby authorizes _____

(Name of Organization)

to release my medical records, and radiological studies to Indianapolis Neurosurgical Group
for the purpose of _____

(Indicate Purpose or Need for Disclosure)

It is understood that this is confidential information and will be treated as such.

I understand that this authorization is valid for sixty (60) days and that it can be revoked by
me prior to that time.

(Signature Of Patient)

Witnessed By: _____

Date: _____

Date: _____

(Relationship If Not Patient): _____

Information Requested: _____

Please send the above records to Dr. _____

_____ 1801 N. Senate Blvd., Suite 535; Indianapolis, Indiana 46202 • Fax (317) 924-8472

_____ 8402 Harcourt Road, Suite 500; Indianapolis, Indiana 46260 • Fax (317) 876-4070

_____ 5508 E. 16th Street, Suite C-20; Indianapolis, Indiana 46218 • Fax (317) 351-0526

_____ 110 N. 17th Street, Suite 120 Bldg. 2; Beech Grove, Indiana 46017 • Fax (317) 781-2510
