GOODMAN CAMPBELL
BRAIN AND SPINE

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 Goodman Campbell Brain and Spine to release information to: _____

_____

☐ I authorize Goodman Campbell Brain and Spine 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 Goodman Campbell Brain and Spine. 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: _____

Witness: _____ Date: _____

Parent/Legal Guardian/Representative of the above patient:_____ 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: _____

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Goodman Campbell Brain and Spine is a merger of Indianapolis Neurosurgical Group and IU School of Medicine Department of Neurological Surgery