Record Release Authorization

I authorize release of my medical records/Imaging reports **to Spine Institute of Schererville**. This information may be **faxed to (219) 864-5872** attention Dr. Joseph Stewart. I understand I have the right to revoke this authorization at any time but I must do so in writing as per privacy policy. I also understand that authorizing this disclosure of this health information is voluntary. I can refuse to sign and need not sign this form in order to assure treatment or be eligible for insurance benefits.

_____ _____
Patient's Signature Date

_____
Patient's name (Please Print)

_____ _____
If Patient is a Minot Signature of Parent Or Legal Guardian Relationship to Patient

_____ _____
Witness To The Above Signature Please Print Name

Acknowledgment Of Receipt Of HIPAA Privacy Policy

I acknowledge that I have received a copy of Spine Institute of Schererville's Notice of Patient Privacy Policy. I understand how my personal health information may be used and disclosed, and how I can get access to this information. I was given a chance to ask questions and any questions I had were answered to my satisfaction.

_____ _____
Patient's Signature Date

_____
Patient's name (Please Print)

_____ _____
If Patient is a Minot Signature of Parent Or Legal Guardian Relationship to Patient