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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____

City/State/ZipCode:_____

Date of Birth: _____ **SS# (last 4 digits)**_____

I hereby authorize **Louise I. Buhrmann, MD, PA** to **( ) release my medical information to and/or ( ) obtain my medical information from** the following doctor, hospital, attorney or other entity:

Name of Doctor/Hospital/Attorney/Other Entity:_____

Approximate Dates of Service/Hospitalization:_____

Address: _____

City/State/Zip: _____

Phone/Fax Number:_____

This release is for the purpose of (please check):

_____**Continuing Medical Care**
_____**Legal Representation**
_____**Other:** _____

I understand that this information may include information of a psychological, psychiatric, AIDS, HIV, alcohol or drug related nature. I recognize that the information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of such information. This authorization will expire one year from the signature date and may be revoked in writing by the patient at any time, except to the extent that action has already been taken in good faith. Information released may be subject to re-disclosure by the recipient. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

_____ _____
Patient/Guardian Signature **Date** **Relationship to Patient**

_____ _____
Witness Signature **Date** **Provider's Authorization to Release**

Revised 5/29/13