

**LOUISE I. BUHRMANN, MD, PA**

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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

I hereby authorize Louise I. Buhrmann, MD, PA to ( ) release to and/or ( ) obtain from the following doctor, hospital, attorney or other entity, my medical records. This release is for the purpose of continuing medical care, legal representation, or 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 Name:** \_\_\_\_\_

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

**City/State/ZipCode:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Name of Doctor/Hospital/Attorney/Other Entity:** \_\_\_\_\_

**Dates of Service/Hospitalization:** \_\_\_\_\_

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

**City/State/Zip:** \_\_\_\_\_

**Phone/Fax Number:** \_\_\_\_\_

\_\_\_\_\_  
**Patient/Guardian Signature                      Date                      Relationship to Patient**

\_\_\_\_\_  
**Witness Signature                      Date                      Provider's Authorization to Release**