Confidential Information Release Form

I, ______________________________authorize Dr. Tara Boyle, Dr. David Beck, Dr. Mary Augustyn, Dr. Brian Schowengerdt, and staff to release any medical information to the following (check all that apply):

_____Primary and Referring Doctors

_____Spouse or Partner

_____Family Members (including parents, siblings, and children 18 years and older)

_____Other Healthcare Facilities

_____None of the above, I want information released only to me

________________________________ ______________________

Patient Signature Date