Lisa B. Arian, M.D.
Lynne Champagne, M.D.

Patient Confidential Records Authorization

Patient Name:_____

I hereby authorize Lisa B. Arian, M.D. and Lynne Champagne, M.D. to release the information stated by me to each of the individuals listed below. I understand that each of the individuals that I list will have access ONLY to the information I have stated and no more. I also understand that I am able to remove any individual and each of their individual privileges to view my information at any time as I see fit, and that Lisa B. Arian, M.D. and Lynne Champagne, M.D. reserve the right to consult with me if they consider it pertinent before all information's release. Any information that is released to a party listed below, who has been cleared by me, is solely my responsibility, and I do not hold any party liable for it's release.

Patient Signature:_____ Date:_____

I Authorize:	To view, receive results, and access only the information listed here:	Nurse's Initials