



**Brian A. Lemper, D.O.**  
Board Certified and Fellowship Trained in  
Pain Management

**MEDICAL RECORDS RELEASE AND FINANCIAL AGREEMENT/AUTHORIZATION FOR  
TREATMENT**

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I hereby authorize treatment of the person named below by Brian A. Lemper, D.O.

Patient Name: \_\_\_\_\_

( Please print full name)

I authorize Brian A. Lemper, D.O. to release any information concerning my healthcare treatment including diagnosis, examinations, and treatments to my insurance companies or other healthcare facilities. I request that payment of authorized Medicare or private insurance benefits be made on my behalf to Brian A. Lemper, D.O. for any services furnished to me.

Should there not be insurance benefits available, I fully understand and accept responsibility for **all** my bills incurred.

This authorization is in effect until I give written notification stating otherwise.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

(Guarantor's Signature)