

# Kristin N. Schmidt, MD, PLLC



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## MEDICAL RECORDS RELEASE

There is a \$25.00 charge for the first 20 pages or less, and \$0.15 for each additional page after 20.  
This fee must be paid BEFORE documents are produced.

Please fill in all blanks. Incomplete or altered forms will be returned by mail for completion before processing.

Allow 2 weeks to process completed requests.

I HEREBY AUTHORIZE:

**Kristin N. Schmidt, MD, PLLC**  
**2222 Greenhouse Rd, Suite 1800 Houston, TX 77084**  
**Telephone 713-464-2100 Fax to 832-321-5593**

To furnish a copy of medical records, which may include information concerning the results and/or treatment of HIV, AIDS, Mental Health, Alcohol and/or Drug Abuse, of the patient listed below. Upon making this request I hereby release you, your physicians and employees from liability for following this authorization request.

For the purpose of:

Insurance Claim Pending  Personal Copy  Moving out of town

Second Opinion  Primary Care Physician  Change in Insurance Plan

Application for Life/Health Insurance  Legal Representation

Transfer care due to: \_\_\_\_\_

\_\_\_\_\_  
Other: \_\_\_\_\_

INFORMATION TO BE RELEASED: Please specify which time period is requested.

Date of Service: FROM \_\_\_\_\_ TO \_\_\_\_\_

Pap Smear  Office Notes  Labs  Mammogram  Operative Report

Prenatal Record  All Records  Other: \_\_\_\_\_

This authorization is valid for 120 days from the date of signature. Any changes in authorization must be in writing.

Regarding (Patient Name) \_\_\_\_\_

SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

**Patient**  
**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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