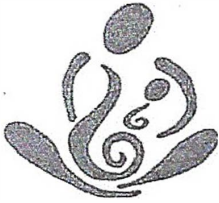


Kristin N. Schmidt, MD, PLLC



Kristin N. Schmidt, MD, F.A.C.O.G
Breanna Barry, N.P.

REQUEST FOR INFORMATION

I HERBY AUTHORIZE (PREVIOUS DOCTOR OR FACILITY) _____ PHONE _____ FAX _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

TO FURNISH A COPY OF MEDICAL RECORDS. THIS 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 REQUEST. I HEREBY RELEASE YOU, YOUR PHYSICIAN AND EMPLOYEES FROM LIABILITY FOR FOLLOWING THIS AUTHORIZED RELEASE FORM

TO: MEDICAL RECORDS
KRISTIN N. SCHMIDT, MD, PLLC
2222 Greenhouse Rd, SUITE 1800 HOUSTON, TEXAS 77084
PHONE 713-464-2100 FAX 832-321-5593

****PLEASE COMPLETE ALL INFORMATION. INCOMPLETE OR ALTERED FORMS WILL NOT BE PROCESSED****

DATE OF SERVICE: FROM _____ TO _____ (PLEASE CHECK ONE)

- PAP SMEAR
- OFFICE NOTES
- LABS
- MAMMOGRAPHY
- OPERATIVE REPORTS
- PRENATAL RECORDS
- ALL RECORDS

THIS AUTHORIZATION IS VALID FOR 120 DAYS FROM THE DATE OF SIGNATURE.
ANY CHANGE IN AUTHORIZATION MUST BE IN WRITING.

PATIENT NAME _____ DATE OF BIRTH _____

SS NO. _____ PHONE _____

ADDRESS _____ CITY, STATE _____

ZIP _____

PATIENT SIGNATURE _____
GUARDIAN, IF MINOR _____ DATE _____

FOR OFFICE USE ONLY

DATE REQUESTED _____ REQUESTED BY _____

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