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 _____