

ROBERT P. SCHMID, M.D., P.A. AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Medical Record # _____

Date of Birth _____ Social Security Number _____

I authorize the following individual or organization to disclose the above named individual's health information:

_____ Address: _____

This information may be disclosed TO and used by the following individual or organization, 4102 24th St., Suite 305., Lubbock, Tx 79410

Robert P. Schmid, M.D., P.A.

For the purpose of _____

Please release the following:

- | | |
|-----------------------------|---|
| _____ Problem List | _____ X-Ray/Imaging Reports – from (date) _____ to (date) _____ |
| _____ Progress Notes | _____ X-ray films |
| _____ History/Physical Exam | _____ Laboratory Results – from (date) _____ to (date) _____ |
| _____ Medical List | _____ EKG Reports |
| _____ Immunization Record | _____ Other Diagnostic Reports (Specify) _____ |
| _____ List of Allergies | _____ Other (Specify) _____ |

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

_____ **YES**, I consent to the release of this information. _____ **NO**, I do not consent to the release of this information.

I understand that the information released is for the specific purpose state above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorized will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provide in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Chad R. Southard at (806) 797-6398.

Signature of Patient or Legal Representative Date

Relationship to Patient (If Legal Representative) Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Robert P. Schmid, M.D., P.A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative Date

Relationship to Patient (If Legal Representative) Witness

From entity
To Schmid