AUTHORIZATION FORM FOR THE RELEASE OF VERBAL/WRITTEN PROTECTED HEALTH INFORMATION

By signing this form, I authorize the following health care provider to use and disclose the protected health information described below.

Provider's Name:______________________________Discipline:____________

Address:____
Street City State Zip Code

Phone:______________________________Fax:______________________

Patient Name:______________________________D.O.B.____________

I hereby authorize the above provider and representatives thereof to obtain from and furnish to:

Ingrid E. Schmidt, M.D. 5750 Balcones Drive, Suite 109, Austin, TX 78731
Telephone (512) 453-2755 Fax (512) 451-6779

The following information about the above named patient pertaining to the services provided:

Please specify____

____

For the purpose of:____

This authorization shall be in force until the following event or date:____________________

- I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification.
- I understand that a revocation in not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy of the policy itself.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- This practice will not condition my treatment, payment, or enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

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Signature of Patient or Personal Representative (Guardian) Date

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Description of Personal Representative or Guardian's Authority/Relationship to Patient