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

By signing this form, I authorize Ingrid E. Schmidt, M.D. to use and disclose the protected health information described below.

Patient Name:_____ D.O.B._____

Check Information to be Released: ____Verbal ____Written ____Both

____Psychiatric Diagnosis ____Psychiatric Medications ____Psychiatric Report

____Brief Psychiatric Summary ____Brief Letter ____Questionnaires

____Other (Specify):_____

For the Purpose of:_____

_____

Release my protected health information to the following person(s)/entity:

Name:_____ Street:_____

City:_____ State:_____ Zip:_____

Telephone: _____ Fax:_____

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.

_____

Signature of Patient or Personal Representative (Guardian) Date

_____

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