

Kristin N. Schmidt, MD, PLLC



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AUTHORIZATION FOR RELEASE OF INFORMATION TO DESIGNATED PERSON(S)

Patient Name: _____ Date of Birth: _____

This form is part of the Federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA) requirements for patient privacy. Signing this form and naming a person(s) who can receive your health information allows the staff of Kristin N. Schmidt, MD, PLLC to release information regarding your healthcare.

Person(s) who can receive information for you:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I hereby authorize the staff of Kristin N. Schmidt, MD, PLLC to use and disclose my individually identifiable health information as described above. I understand that once this information is disclosed, the released information may no longer be protected by federal privacy regulations. This authorization shall be in force and effective until you make any changes. It is your responsibility as the patient to update our office with any changes to this form.

Signature of patient or patient's guardian/representative

Date

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