Kimberley A. Schroeder, D.O.
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MEDICAL RECORDS RELEASE

PATIENT NAME: DATE OF BIRTH:

I authorize KIMBERLEY A. SCHROEDER D.O., P.A. to ☐ release to: ☐ release from:

DOCTOR / ORGANIZATION / INDIVIDUAL	PHONE	FAX

ADDRESS / CITY / STATE / ZIP

The following Information:

- ☐ ALL MEDICAL RECORDS
- ☐ CLINICAL NOTES ONLY
- ☐ LAB / X-RAY REPORTS ONLY
- ☐ RESTRICT TO THE FOLLOWING DATES / CONDITIONS:____
- ☐ OTHER: ____

Disclosure is for the following reason(s):

- ☐ PERSONAL RECORDS
- ☐ CONTINUED MEDICAL CARE
- ☐ INSURANCE CLAIM
- ☐ LEGAL ACTION
- ☐ OTHER: ____

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writing here: ____

I understand that in order for this authorization to be revoked, I must submit the request in writing to the Institute for Health and Wellness.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

PRINT NAME OF LEGALLY AUTHORIZED REPRESENTATIVE RELATIONSHIP TO PATIENT