Shari Rosen-Schmidt, M.D., P.A.
Charisse H. Barta, M.D., P.A.
Joel D. Campbell, M.D., P.A.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

___ Shari Rosen-Schmidt, MD ___ Charisse Barta, MD ___ Sudama Reddi, MD ___ Joel D. Campbell, MD

Patient Name: ____

DOB: ________________________ Social Security #: ______________________________

Receive Records From: ______________________________
____
____

Release Records To: ______________________________
____
____

Please send a copy of my records as indicated for date(s) of service (if known):_____________

____Complete Record
____History & Physical
____Nurse's Notes
____Progress Notes
____Discharge Summary
____Patient Demographics/Insurance Card
____Radiology Reports
____Consultation Reports
____Physician's Orders
____Operative Reports
____Radiology Films/Discs
____Admission/Registration
____Emergency Room
____Laboratory Reports
____Billing Records
____Other ______________

Purpose for releasing medical information: ____

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

____
SIGNATURE OF PATIENT / GUARDIAN

____
DATE

____
PRINTED NAME OF PATIENT OR GUARDIAN

*______________________________
RELATIONSHIP TO PATIENT

** If signed by a Legal Guardian, documentation must be attached.*

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