Dr. Jennifer Schmidt
40900 Merchants Ln. Suite 202
Leonardtown MD 20650

NPI 1568486025
Ph: 301-997-1155 or 1-888-775-2525
Fax: 301-769-6446

Record Release

To:_____

_____

Patient Name:_____D.O.B._____

The undersigned hereby authorizes and requests you to provide Dr. Jennifer Schmidt with a copy of the medical records of the above named patient.

_____ The medical records concerning the period from _____to _____
OR
The specific items specified below:

_____ECHO _____EKG _____Medication List _____problem list

_____Most recent laboratory results, ___Other:_____

_____Consultations by:_____

I understand that the medical records to be released may contain information related to HIV/AIDS status, sexually transmitted diseases, alcohol use, drug use or mental services and I hereby authorize the release of this information.

This authorization for disclosure is valid for two (2) years and may be withdrawn by me at any time in writing.

_____ _____
Patient Signature or Guardian Date

_____ _____
Witness Signature Date