AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize Dr. William Schnitz, M.D. to release photocopies of my medical records and/or health information.....

- To a third-party payer (insurance company) to verify that services were billed as actually provided.
- To health professionals who contribute to my care.
- Into my own keeping.
- To the following named individual or organization: _____

_____

I agree to pay 50 cents per page for each copy (per Oklahoma Statute) before such are released and will also pay the actual cost of postage if the record is to be mailed. This is to cover all supplies used by Dr. William Schnitz in the process of sending my records.

I further release Dr. William Schnitz from the responsibility for any deleterious effect the release of my clinical medical records may have, upon myself or others, both now and in the future. I personally accept all responsibility for my own distribution and interpretations of medical information contained therein and hold blameless Dr. William Schnitz for conclusions or opinions drawn from said records without professional knowledge, assistance, or review.

State law, you must be advised that: **The information authorized for release may include records which may indicate the presence of a communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS).**

I realize by the release and/or receipt of these records that I am accepting responsibility for the protection of my own right of medical record confidentiality.

Please circle one:

You **can cannot** leave appointment reminders or medical information on my message service or machine.

_____ _____

Signature of patient Date

_____ _____

Signature of person authorized to sign if other than patient. Relationship to patient than patient.