John A. Schmidt, Jr., M.D.
2006 Highway 71, Ste. 3
Spring Lake Heights, NJ 07762
732-282-8166

Request for Release of Medical Information

I hereby and voluntarily authorize _____ , located at _____, to release my medical records to the above named physician.

Description of Information to be released (Please check all appropriate boxes):

☐ **Office Notes**

☐ **Admission and Discharge Summaries**

☐ **Laboratory Results**

☐ **XRAY, CT, Ultrasound, and/or MRI results**

From (M/D/Y) ___/___/___TO (M/D/Y) ___/___/___

Name of Patient: _____Patient's DOB _____ Patient's SS#_____

Signature of Patient or Authorized Representative: _____Date: _____

Name of Representative (please print): _____

Relationship to Patient: _____

Please Note: Authorization may be withdrawn at any time prior to transfer of information by notifying above named physician in writing. Authorization will automatically expire within ninety days from date given.