Clifford H. Schilke M.D.

Release of Medical Records

Release of Medical Records: I authorize Clifford H Schilke, MD to release verbally, electronically and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for the purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not release my medical records to a specific entity and/or person(s) I must specifically state so in writing for inclusion in my medical record.

Patient Signature_____

Date_____