Isaac Kramer, MD

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Patient Authorization Form

RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

I,_____
_(print **your** name and date of birth)

ask Dr._____(Fax:_____)
(please write the **fax number**)

to send copies of my medical records to:

Dr Isaac Kramer
Fax: 973-716-0005

_____

My special requests for information release and/or communication include_____

_____.

_____ _____
Your Signature Date

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*Please **fax the records to 973-716-0005**.*