



Isaac Kramer, MD

Diplomate

American Board of Internal Medicine

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Record Transfer Authorization Form

RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

From: _____ (print **your** name)

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

Please send copies of my medical records to:

Isaac Kramer, MD
349 East Northfield Road, Suite 101
Livingston, NJ 07039
Tel: 973-716-0300
Fax: 973-716-0005

My special requests for information release and/or communication include _____

_____.

Your Signature

Date

*We prefer if you **fax the records to 973-716-0005.***

Isaac Kramer, MD