Scott Kramer MD

Comprehensive, Contemporary, Compassionate Care for Women

**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION AS REQUIRED BY HIPAA PRIVACY RULES**

_______________________________________________ _______________

Name of Patient (Print) Birth Date

_______________________________________________________________

Street Address City State Zip

_(__________)__________________________________

Cell or Daytime Phone Number

**Authorizes Release of Protected Health Information—From:**

_______________________________________________

_______________________________________________

_______________________________________________

**To:**
**Scott Kramer MD**
2333 Mowry Ave., Suite 201
Fremont, CA 94538

**FAX Medical Records to (888) 811-0578**

**Information To Be Released:**

✓ Medical Records (past 3 years inclusive of health care summary, clinic notes, labs, imaging studies, consultant's notes; past 10 years for pathology reports, hospital & operative records)

Other: _______________________________________________

**Purpose For Need Of Disclosure:**

Continuation of Medical Care

_______________________________________________

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

**Your Rights With Respect To This Authorization:**

**Right to Inspect or Copy the Health Information to Be Used or Disclosed -** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the medical records department of the Washington Township Medical Foundation. **Right to Receive copy of This Authorization -** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the medical records department of Washington Township Medical Foundation. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

**Expiration Date:** This authorization is good until the following date(s) or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

**Signature of Patient or Legal Representative:**_______________________________ **Date:**____________

*(If signed by other than patient, state relationship and authority to do so.)*

**Patients please fax completed form to (888) 811-0578 or mail to office**



www.ScottKramerMD.com