KRAMER
PSYCHIATRIC SERVICES, LLC

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Date of Request: _____

Name: _____ DOB: _____ SSN: _____

Address: _____

Phone: _____

I, _____, authorize:

Kramer Psychiatric Services, LLC
3925 N. I-10 Service Rd. W., Suite 201E
Metairie, LA 70002
504-800-6750

☐ **To Release information to:** ☐ **To Obtain information from:**

_____
Person/Entity

_____
Address

_____
City State Zip

_____
Phone Email

The Purpose of this Authorization is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action
☐ Changing Physicians ☐ Research related treatment
☐ Creating health information for a disclosure to a third party
☐ Other: (Specify) _____

I authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the information you want released or obtained)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ Treatment or Tests
☐ Prescriptions ☐ Immunizations ☐ Hospital Records including Reports ☐ Lab Reports
☐ X-ray Reports ☐ I/DD Records
☐ Other: (Specify) _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

☐ Alcoholism ☐ Drug Use ☐ Mental Health ☐ Vocational Rehab ☐ HIV (AIDS)
☐ Sexually Transmitted Disease ☐ Genetics ☐ Psychotherapy Notes
☐ Other: (Specify) _____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____

I understand that if I do not specify an expiration date, this authorization will expire one (1) year from the date on which it was signed. I acknowledge that I have read and understand this entire form. I authorize a copy (including electronic, oral, or paper) of this form for the disclosure of the information described above.

_____ _____
Patient Signature or Authorized Representative Date