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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
To Dr. Klausner

I hereby authorize the following medical records source:

Name:_____
Address:_____
City_____State_____Zip_____
Phone_____fax:_____

to furnish to **Dr. Robert Klausner** (circle one):

complete or limited to_____

with exclusion of the following:_____

_____

medical and/or surgical records

of_____DOB_____

This includes extremely confidential medical records such as HIV/AIDS testing , sexually transmissible disease, psychiatric or psychotherapeutic records, unless specific exclusion is noted below.

Exclusions:_____

Whatever privilege afforded by law is hereby waived.

Signed:_____ Relationship:_____

Address:_____ Date:_____

City, State, Zip:_____ Phone:_____

Initiating Staff Initials:_____ Date_____
Completing Staff Initials_____ Date_____