Authorization for Release of Medical Records to Dr. Schramm

Patient Name: _____ Birthdate: _____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct:

Provider Name:

Full Address:

Fax:

To disclose my health information during the term of this Authorization to:
Laurel J. Schramm, M.D., 6310 San Vicente Blvd., Suite 290
Los Angeles, CA 90048
Tel: (323) 965-1616 • Fax: (323) 965-1618

Purpose: I understand that the specific purpose of this Authorization is:

- ☐ medical care other: _____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

- ☐ all of my health information that the provider has in her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from other health care providers.
- ☐ all of the above except for the following: _____
- ☐ immunization records only
- ☐ only the following records or types of health information: (please specify dates or type of treatment) _____

Term: This authorization will remain in effect for one year from the date it is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health care information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke at any time this Authorization for any reason and that this will not affect my treatment.

Revocation: I understand that this Authorization will remain in effect for one year or until I provide a written notice of revocation to the above-named health care provider's office. The revocation will take effect immediately upon receipt, but will not affect any actions taken before the notice was received.

Questions: I may contact my health care provider at his or her office by telephone or mail for answers to my questions about the privacy of my health information. I understand that I have a right to receive a copy of this authorization.

Photocopy: A photocopy, fax or electronic copy of this authorization shall be considered as effective and valid as the original.

Parent Signature: _____ Parent name (print):_____

Relationship to patient: _____ Date: _____

Patients who have reached the age of 18 or more must sign instead of the parent.