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Authorization Form
Release of Information (PHI)
Date: _____

I, _____ _____,
Name Date of birth

hereby authorize Dr. Kroemer to share information pertaining to my care with

_____
NAME

_____
Street address

_____
city, State, zip

_____ _____
TEL FAX

I authorize the following to be released:

_____ treatment summary

_____ progress notes

_____ psychological evaluation

_____ verbal communication

_____ other: _____

_____ _____
SIGNATURE DATE