Kraus Behavioral Health, LLC.

Authorization for Release of Information

**Please complete with as much information as possible.*

Patient Name: ______________________________ **Date of Birth:** __________________

Street Address: ____

City: ____________________________ **State:** ____________ **Zip:** ______________

Phone #: __________________________ **Email:** ______________________________

I am authorizing that information be shared with:			
Name of Individual/Entity:			
Relation to Patient:			
Street Address:			
City:		**State:**	**Zip:**
Phone #:		**Fax #:**	

Specific Information To Be Released/Shared: *(Please check at least one. Do not leave blank!)*

- ☐ Medical/Mental Health Records
- ☐ Appointments
- ☐ Billing/Payment/Balances
- ☐ Labs/Bloodwork
- ☐ Radiology
- ☐ Other: ______________________

Purpose of Request: *(Please check at least one. Do not leave blank!)*

- ☐ Coordination of Care (sharing records between providers)
- ☐ Insurance Application
- ☐ Disability Application
- ☐ Procedural Pre-Approval
- ☐ Personal Record
- ☐ Other: ______________________

Notes:

By signing this form, I hereby authorize Kraus Behavioral Health, LLC. to receive information from and/or release a copy or a summary/narrative of my confidential medical information to the above-named physician/person/facility/entity/family member listed above. I understand that authorizing this disclosure of information is voluntary and that I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon it, by sending such notification to Kraus Behavioral Health, 7001 Johnnycake Road, Suite 107, Windsor Mill, MD 21244.
I understand I may inspect the information to be used or disclosed. ****Note:*** *Revoking the request will not include information that has already been disclosed based on your previous permissions.*
Furthermore, I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient. Kraus Behavioral Health is released and discharged from any liability, and the undersigned will hold Kraus Behavioral Health harmless for complying with this release.

______________________________________ ____________________

Patient or Authorized Representative *(Signature)* **Date**

**If Authorized Representative:*

______________________________________ ____________________

Authorized Representative Name *(Print)* **Relation to Patient**

Please notify the receptionist if you would like a copy of this form for your records.