Kraus Behavioral Health, LLC.

Authorization for Release of Information

*** Incomplete forms will delay (and may prevent) processing ***

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

Street Address: ____

City: ____________________________ **State:** ______________ **Zip:** ________________

Phone #: __________________________ **Email:** _____________________________________

I am authorizing that information be ☐ REQUESTED FROM: *or* ☐ PROVIDED TO:

Name of Individual/Entity: ____

Relation to Patient: ____

Street Address: ____

City: ________________________________ **State:** ______________ **Zip:** __________

Phone #: _____________________________ **Fax #:** ____________________________

☐ **This is a general authorization for shared communication. No specific records requests are being made at this time.**

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

I understand that the information in my health record may include information relating to sexually transmitted disease, sickle cell anemia, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and/or information about alcohol/substance/drug use and/or treatment.

☐ Medical/Mental Health Records
☐ Appointments
☐ Billing/Payment/Balances
☐ ADHD Testing Information
☐ Labs/Bloodwork
☐ Radiology
☐ Genetic Testing Information
☐ 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: ____________________________

This authorization will expire upon completion of care, unless a specific date or event is provided:

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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 have no effect on information that has already been disclosed based on your previous permissions.* Furthermore, I understand that information disclosed to any above recipient may no longer be 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* (please print name & relation below):*

____ ____________________________

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

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