

# CRIAG C. KRAUSE, M.D.

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## AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous

Name: \_\_\_\_\_ Healthcare ID #: \_\_\_\_\_

I request and authorize Lake Manassas Medical Psychiatry, PLC to  Exchange with  Release to  Receive from the following  
Provider/Organization/Individual:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This request and authorization applies to:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> assessment/clinical summary | <input type="checkbox"/> emergency information              | <input type="checkbox"/> detoxification information |
| <input type="checkbox"/> treatment plans             | <input type="checkbox"/> discharge plans                    | <input type="checkbox"/> treatment recommendations  |
| <input type="checkbox"/> progress in treatment       | <input type="checkbox"/> psychiatric information/evaluation | <input type="checkbox"/> other:                     |

THIS AUTHORIZATION AUTOMATICALLY EXPIRES ONE YEAR FROM THE DATE IT IS SIGNED

— OR —

- A single use or disclosure at the time of authorization
- Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Revoked by the patient \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
- Record closed on : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Other \_\_\_\_\_

This release (check one)  includes  does not include information placed in the record after the date I sign this form.

I understand that:

Service providers using or disclosing information based on this authorization are to share the minimum necessary amount of the specified information to accomplish the purpose of the disclosure outlined above. The provision of treatment, payment, enrollment, or eligibility for benefits does not depend on whether I sign this authorization, unless I am participating in treatment as a condition of my criminal justice status. I may revoke (or cancel) this authorization at any time by submitting a written statement of revocation to one of the Lake Manassas Medical Psychiatry staff contacts listed in the the Notice of Privacy Practices, except to the extent that the identified service providers already have taken action based on this authorization, or if I am participating in treatment as a condition of my criminal justice status. The information to be released has been fully explained to me and this authorization is given of my own free will. I am entitled to a copy of this signed authorization.

These records (select only one).

- Are protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are protected by 42 CFR, Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- Are NOT protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal HIPAA regulations.

By signing below, I authorize this release

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Signed: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_  
Signed: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
Signed: \_\_\_\_\_