Stephanie K. Kraft MD, PC
10371 Parkglenn Way #290
Parker CO 80138-3879
Phone 720-851-9533 FAX 720-851-9553

Authorization of Release of Medical Information

(Please print neatly and legibly)

Patient's Name: ______________________________ **DOB: _____________________**

Phone #: ____________________________________ **SS #: _____________________**

Address: ____

I authorize records: (Please select one)

[ ] To be released ***TO*** Dr. Stephanie Kraft, M.D. from ____

Address: ____

Phone: ____________________________ Fax: _______________________________

[ ] To be released ***FROM*** Dr. Stephanie Kraft, M.D. to ____

Address: ____

Phone: _____________________________ Fax: ______________________________

I request release of the ***complete health record (s)*** for ***all dates of service*** unless specified here:

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The purpose of this disclosure is for ***treatment/payment/healthcare operations*** unless specified here:

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This authorization gives Dr. Stephanie Kraft, M.D. permission to request your medical records from any health care provider that you have received treatment from as specified above for the duration that you have a direct treatment relation with Dr. Stephanie Kraft, M. D. Dr. Stephanie Kraft, M.D. is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State laws and regulations. **This includes any and all alcohol &/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless otherwise specified above.** Dr. Stephanie Kraft, M.D. is released and discharged from any liability, and the undersigned will hold Dr. Stephanie Kraft harmless for complying with this information. I understand that I am not required to sign this authorization. I understand that I may revoke this authorization at any time by presenting my written revocation for Dr. Stephanie Kraft, M.D., 10371 Parkglenn Way, Suite #290, Parker, CO 80138. I understand that the revocation will not apply to information that has already been used or released under this authorization. I understand that physician's office has the right under Colorado stated law to require payment up front for reasonable costs of copying and mailed before furnishing the medical records.

____ _____________________________________

Signature of Patient or Legal Representative Printed Name of Patient or Legal Representative

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Date