# Dana Krafchick, M.D.

**DIPLOMATE AMERICAN BOARD PSYCHIATRY AND NEUROLOGY * ADULT, CHILD AND ADOLESCENT PSYCHIATRY**

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## CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name_____ Date of Birth_____

I, _____, hereby authorize the mutual exchange of information

between Dana Krafchick, M.D. and

_____
Name of hospital, physician, clinic, school, teacher, etc.

_____
Address of hospital, physician, clinic, school, teacher, etc.

_____
City, State, Zip Code

_____ _____
Telephone number Fax number

I understand that information to be released for the purpose of psychiatric evaluation and ongoing treatment may include information regarding the following conditions(s):

_____Psychiatric Conditions, Psychological Testing, Progress notes, Medications prescribed
_____Assessment including Diagnosis
_____Treatment Summary, Recommendations, Consultation
_____Medical Information
_____Educational Information
_____Drug and/or Alcohol abuse
_____HIV/AIDS

I understand that I may revoke this consent to release medical information at any time by giving written notice to Dana Krafchick, M.D. except to the extent that action has already been taken to comply with it. Without such revocation, this consent is valid until treatment with Dr. Krafchick ends. I release Dana Krafchick, M.D. from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be redisclosed by the recipient and thus no longer protected under the HIPPA privacy rule.

I understand there is a charge for records copied/summarized for personal, attorney or insurance purposes. Based on Colorado State Statutes, the charge for copying is $14.00 for the first 10 pages; $0.50 per page for pages 11-20; and $0.33 for each additional page. The charge for summaries is $25.00. If you receive a summary and copies of records, you will be charged both fees.

**Initial**: _____

Signature of Patient _____Date_____
(if 15 years or older)

Signature of Parent or Legal Guardian _____Date_____
(if patient under 18 years old)

Relationship to patient_____

Signature of Witness_____Date_____

**A photocopy or fax of this document shall be as effective as the original**