Peter Krause Medical Corporation
2151 S. College Drive, Suite 203
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my current health care provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):
Peter Krause, MD
2151 S. College Drive, Suite 203
Santa Maria, CA 93455

Purpose: I authorize the release of my health information for the following specific purpose:

_____.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me. (last 2 years)

- ❑ Only the following records or types of health information:
  _____.

Term: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

_____ _____
Signature Date

Medical records requests may be subject to a fee. Please inquire with office prior to submitting request.