Medical Information Release Authorization

Patient's Name			
Mailing Address		**City**	
State		**Zip**	
SSN		**DOB**	

The undersigned hereby authorizes any medical practitioner, hospital, facility, insurance company or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein, to release such information upon request to The Karis Group for the purpose of The Karis Group negotiating medical bills on the undersigned's or dependent's behalf.

The undersigned hereby grants permission to The Karis Group to discuss any and all medical bill related information with any medical practitioner, hospital, facility, insurance company or any other agency that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein for the purpose of The Karis Group negotiating medical bills on the undersigned's or dependent's behalf.

The undersigned understands that:

- I may revoke this medical information release at any time, in writing, but the release shall remain valid until revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include medical records of treatment for physical and/or emotional illness, except psychotherapy notes, including treatment of alcohol or drug abuse.
- The Karis Group will maintain the privacy of any information obtained and will not disclose such information to any other person or entity except as necessary to effectuate service or by express written permission by me.
- A copy of this form, including a facsimile, may be used in place of the original.

I acknowledge that I have read and understand this Medical Information Release Authorization. Further, I authorize the disclosure of my protected health information in accordance with the terms in this Authorization.

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Signature

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Signature of Parent/Legal Guardian if Patient is a Minor

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Patient's Name

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Date