5113 Southwest Parkway Ste 175
Austin, Texas 78735

Medical Information Release Authorization

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

I (signer below) hereby authorize any medical practitioner, hospital, facility, insurance company or any other person or entity that has my medical records or knowledge of my medical records and/or the dependents listed herein, to release such information upon request to The Karis Group for the purpose of The Karis Group advocating or negotiating on my or dependent's behalf. This release shall be limited to the medical bills or incident(s) I have specifically requested or authorized The Karis Group to negotiate or assist me with.

I hereby grant 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 my medical records or knowledge of my medical records the dependents listed herein for the purpose of The Karis Group negotiating medical bills on my or the dependent's behalf.

I understand 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 or scan, 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 or the dependent's protected health information in accordance with the terms in this Authorization.

____
Signature of Patient
(or Parent/Legal Guardian if Patient is a minor)

____
Date Signed

Optional: If it is necessary for someone other than your spouse to discuss your medical bills or finances with The Karis Group, please provide the individual's name below to appoint and authorize them to act as your personal representative for this limited purpose:

____

Personal Representative

To return by mail or fax:

The Karis Group, 5113 Southwest Parkway Ste 175, Austin, TX 78735

Fax 512.828.8165 | Phone «CLIENT_TOLL_FREE» | www.thekarisgroup.com