Consent for Request/Release of Medical Records

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

_____

_____

I, _____, hereby authorize _____
(Provider's Name)

_____ _____
(Provider's Phone)

_____

_____
(Provider's Address)

to provide my medical record and pertinent information to the **Ketamine Wellness Clinic** for the purpose of initiating/continuing treatment. I understand that areas of my medical record *including information pertaining to mental health, drug and/or alcohol abuse will be included unless I specify that the following areas are not be released*;_____

_____

I understand that I have a right to receive a copy of this request. This consent for the release of my medical information shall remain valid until _____.
(Specified End Date)

_____ _____
(Patient's Signature) (Date)