Ketamine Wellness Clinic of Orange County
www.ketamineoc.com

Consent for Request/Release of Medical Records

Patient Name: ______________________________ DOB: ____________

Address: ____________________________ Phone: _______________

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

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____________________________________ ____________________________
(Provider Phone)

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(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*;________________________________

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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 ______________________.
(Specific End Date)

___________________________________ ___________________
(Patient Signature) (Date)