CONSENT FOR REQUEST / RELEASE OF MEDICAL RECORDS

KETAMINE WELLNESS CLINIC ORANGE COUNTY

Please complete and send this form to Ketamine Wellness Clinic of Orange County.

Patient's Name (Last, First) _____

Patient's Date of Birth _____/_____/_____ Patient's Phone (_____) _____-_____

Patient's Address _____

City _____ State _____ Zip _____

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

Provider's Phone (_____) _____-_____

Provider's Address _____

City _____ State _____ Zip _____

to provide my medical record and pertinent information to the **Ketamine Wellness Clinic of Orange County** 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 to 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, _____/_____/_____.
(Specific End Date)

Patient Signature _____

Date _____/_____/_____