Release of Medical Information Consent Page 1

I hereby authorize the Ketamine Wellness Institute (Practice), or any of its employees, staff, or agents, to use and disclose protected health information (PHI) from the medical record(s) of:

Patient name: _____

Patient Address: _____
(Street) (City) (State) (ZIP)

Date of birth: _____

Release information to:

_____

(Name of individual or organization)

Address:
(Street) (City) (State) (ZIP)

Initial all that apply:

I consent to have all the medical information regarding my treatment or hospitalization from my:

_____ General hospitalization or outpatient care

_____ Drug and alcohol treatment care

_____ Infection with human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS)*

_____ Emergency room visit

_____ Psychiatric care

*requires special consent

I am requesting the following information to be released:

_____ Abstract of record (includes: history and physical, operative reports, consultations, discharge summaries, laboratory findings, radiology reports, and other significant findings)

_____ Entire medical record

_____ Other: _____Labs _____Slides** _____X-rays**

**I am aware that there are separate fees for and consents for X-rays, slides, and medical records, etc.

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment

Consent for Release of Medical Information Page 2

_____ Litigation for review

_____ Insurance (company name):

_____ Other (specify reason):

This consent permits the Practice to use and disclose my protected health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of protected health information is described in the Practice's notice of privacy practices. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and healthcare operations purposes. However, the Practice is not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE the Practice, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ (Print patient's name)

_____ (Signature of patient) Date: _____

_____ (Signature of legally authorized person)