Ketamine Center of Greater Hartford

Medical Communication Release Form

Patient Name _____

Date of Birth _____ **Phone** _____

The following individual/organization is authorized to disclose/receive my information:

Physician _____

Address _____

Phone _____ Fax _____

This information may be disclosed/received and used by the following individual/organization:

Ketamine Center of Greater Hartford
302 West Main Street, Suite 153, Avon, CT 06001

Phone: (860) 404-5683
Fax: (860) 264-1511

This authorization covers the period of healthcare

❑ _____ to _____

OR

❑ all past, present, and future periods

Extent of Authorization (initial one):

____ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

____ I authorize the release of my complete health record with the exception of the following information:

❑ Mental health records ❑ Communicable diseases (including HIV and AIDS)

❑ Alcohol/drug abuse treatment ❑ Other (please specify): _____

I understand that:

1. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
2. therapy requires coordination with other providers and treatment is predicated on this coordination.
3. I may see (no cost) or obtain a copy (copying fee) of the material obtained via this form. I understand that I may obtain a complete copy of my medical record for a copying fee.
4. my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____

Signature of Patient (or Representative) **Print Name (Relationship)** **Date**