AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I _____ authorize RefoundCenter to:

☐ **Obtain From** and/or ☐ **Release To:**

Person or Facility and Relationship to Patient:

_____

Email: _____ **Phone:** _____ **Fax:** _____

Time Frame *(this release does not expire unless revoked or a specific end date is noted)*:

_____

I understand that my records cannot be disclosed without my written consent except as otherwise provided by law. I understand that I am not required to consent to this disclosure but choose to do so voluntarily.

Please release the following: ☐ Entire Record ☐ Progress Notes ☐ Treatment Plans ☐ Physical Exam ☐ Notice of Admission ☐ Lab Reports ☐ Medication Notes ☐ Summary ☐ Consults ☐ Ketamine Treatment Records ☐ Psychological/Psychiatric Testing ☐ Other, please specify: _____

This information is needed for: ☐ Ongoing Treatment ☐ Aftercare ☐ Referral ☐ Other: _____

Limitations on disclosure, if any: _____

The information to be disclosed may include confidential information as initialed below:

____ Psychiatric Evaluation/Treatment ____ Ketamine Infusion Treatment Records ____ HIV Test Results ____ Venereal Disease/STI/STD ____ Alcohol/Drug Use (past or present)*

NOTE: This information has been disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical information is NOT sufficient for this purpose.

I release RefoundCenter from all legal responsibility or liability arising from this disclosure and understand that I may revoke this consent at any time unless action on this release has already begun in good faith.

Signature: _____

Printed Name: _____

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Relationship to Patient *(if signing on behalf of patient)*: _____

Date: _____
