



SUMMIT KETAMINE INNOVATIONS

HIPAA Release of information AUTHORIZATION FORM

I, _____ hereby authorize
(Name): _____ (PhoneNumber): _____, to
release to Summit Ketamine Innovations, my personal health information maintained by
_____ (Practice)
(e.g., information relating to the diagnosis, treatment, claims payment, and health care services
provided or to be provided to me and which identifies my name, address, social security number,
Member ID number) except the following information about me:

I understand that any personal health information or other information released
to the person or organization identified above may be subject to re-disclosure by such
person/organization and may no longer be protected by applicable federal and state privacy laws.
This authorization is valid from the date of my representative's signature below and shall
expire within 6 months or if the patient revokes permission.

I understand that I have a right to revoke this authorization by providing written notice
to _____. I also understand that I have a
right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this
authorization.

Name of Member: _____
Signature of Member: _____ Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified
above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers,
etc.) that I am legally authorized to act on the Member's behalf with respect to this
authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____