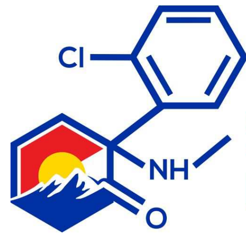

SUMMIT KETAMINE INNOVATIONS

HIPAA Release of information AUTHORIZATION FORM

I, ____hereby authorize
(Name):_____________________________(Number):______________________, to release to
(Name):_____________________________(Number):______________________, my personal
health information maintained by ____

(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: ____________________________________