AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

DATE: _____

PATIENT NAME: _____ DOB: _____

I request and authorize _____ to release healthcare information of the patient name listed above.

Please send all information to:

Klarity Ketamine Wellness Clinic – Dr. Melissa Reed
997 E County Line Rd Suite M
Greenwood, IN 46143
317-777-1034
Toll-Free Fax 855-277-4349
reedmd@tryketamine.com

This authorization applies to:

- All healthcare information regarding assessment, diagnosis, and treatment of patient's condition or disease
- Healthcare information relating only to the following treatment, condition, or dates: _____
- Other: _____

PATIENT SIGNATURE: _____ DATE: _____