JACKSON HOLE
KETAMINE CLINIC

Authorization to Use & Disclose Protected Health Information

Information of Patient for Whom Authorization is Made:

Full Name: _____ Date of Birth: _____

Authorized Person to Disclose Protected Health Information:

Doctor/Therapist (circle one): _____

Address: _____

_____

Phone Number: _____

Email Address: _____

The patient named above authorizes health information to be requested by/released to representatives of:
Jackson Hole Ketamine Clinic
Phone Number: (307)203-4698
Email Address: info@jacksonholeketaminecclinic.com

Description of Information to be Disclosed (please check one):

All of the health information that the provider has in his or her possession including information relating to any medical history, mental or physical condition, and any treatment received by me: _____

Only the following records or types of health information: _____

_____

This authorization is to remain in effect until (please check one):

1 year: _____ Until the following date: _____ Until I provide written revocation: _____

A note regarding the completion of my ketamine course may be sent back to my Doctor/Therapist (please circle one): _____

By signing this form, I agree to the uses and disclosure of the information as described.

Full Name: _____ Date: _____

Signature: _____

PLEASE EMAIL TO: info@JacksonHoleKetamineClinic.com