Authorization to Use or Disclose Protected Health Information

Information of Patient for Whom Authorization is Made

Full Name _____ Date of Birth _____

Authorized Person to Disclose Protected Health Information

(Please note that incomplete information will delay processing.)

Doctor/Therapist _____

Address _____

Phone _____

FAX _____

Email _____

The patient named above authorizes health information to be requested and released by representatives of:

Portland Ketamine Clinic / Dr. Enrique Abreu
Phone (503) 207-4992
FAX (503) 961-8959

Description of Information to Be Disclosed (Please check one.)

- ☐ All of my 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.

Signatures

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

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date

If legal representative, relationship to patient: _____