Iowa Ketamine Services, PLC

HIPAA Release of information
AUTHORIZATION FORM

I, _____hereby authorize _____, to release to Iowa Ketamine Services, PLC, my personal health information maintained by _____ (e.g., information relating to the diagnosis, treatment, 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 I have a right to revoke this authorization by providing written notice to the clinic.

I 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: _____ Date of birth: _____

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: _____

Information requested at this time: Diagnosis list & medication list

Please fax records to: Iowa Ketamine Services, PLC – 319-531-7989
Or, email to: drhodges@ketamineiowa.com