MEDICAL RECORDS RELEASE AUTHORIZATION FORM

Complete the form below and submit to your healthcare provider. This form can be downloaded and printed.

Patient Information

First Name, MI, Last Name

Date of Birth (mm/dd/yyyy)

Phone

Address

City, State, Zip

HealthCare Provider Information

The above patient is (or has been) a patient of the following healthcare facility/provider:

Provider/Facility (Name, Phone number)

Provider/Facility Address (Street, City, State, Zip code)

The above patient authorizes the above healthcare facility/provider to release all medical records and to discuss health information with the following healthcare facility/provider:

Minnesota Ketamine Clinic
Attn: Dr. Gregory Simelgor
4444 West 76th St Suite 500
Edina, MN 55435
Tel (952) 564-5764 Fax (952) 500-8323

☐ I understand that release of medical records may include patient histories, office notes, and working diagnoses. It may include drug, alcohol or substance abuse records, mental health records, procedural and surgical records, test results, and current and past medications and treatments. Authorization is valid for 90 days from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily. By submitting this form, I certify that I have completed this questionnaire to the best of my ability.

Patient's Name (please print)

Patient's Signature

Date (mm/dd/yyyy)

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