Ketamine Institute of Michigan

RELEASE OF MEDICAL RECORDS

I hereby consent and authorize _____
to release copies of my medical records.

Patient name _____

Address _____

City, State and Zip Code _____

Phone _____

Date of birth _____

Last four digits of Social Security number XXX-XX- __ __ __ __

Records are requested by:

Dr. Julia Aharonov
Ketamine Institute of Michigan
461 W. Huron- 7th floor
Pontiac, MI 48341
855-KETAMINE or (855) 538-2646
Fax: 248-857-7021
Email info@ketaminecenter.org

Please select the following documents that apply to your request:

- ☐ Clinic notes
- ☐ Progress notes
- ☐ History and physical
- ☐ Medication orders

Patient Signature _____ Date _____