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
4777 Outer Drive E. Unit 2 West
Detroit MI 48234
855-KETAMINE or (855) 538-2646
Fax: 313-369-5838

Securely Submit Documents Here:
https://www.paubox.com/Ketamine_Institute_Of_Michigan/upload

Please select the following documents that apply to your request:

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

Patient Signature ______________________________ Date ____________