HIPAA Authorization for Release of Information

I, ____, hereby authorize Herman Rus Medical Corporation dba Soft Reboot Wellness to release and to obtain the following information from my mental health and medical records: **history, evaluations, examinations, studies, diagnoses, formulations, and treatments** to and from the following individual(s)/agent(s):

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In authorizing this release of information, I understand it will be used solely for the purposes of **coordination/determination of care and treatment planning** both now and in the future. This notice expires in one year or on the following date: ______________________.

I understand that I have a right to meet with my clinician to inspect my records for information related to my mental health and/or treatment. I further understand that this information cannot be re-disclosed without my express authorization and that the HIPAA requires this notice.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

______________________________ ______________________

Signature of Patient/Guardian Date

Release of Medical Information

In case of emergency, I hereby authorize my ketamine provider to disclose my medical records to EMS and to the individual(s) listed above, or the appropriate personnel in his or her office. I further authorize the individual listed above to disclose my medical records, including any history of substance use or abuse, to my ketamine provider, or appropriate personnel in his or her office. I also authorize my ketamine provider to discuss my care and share my medical information for the purposes of monitoring, quality control or safety concerns.

______________________________ ______________________

Signature of Patient/Guardian Date

Alternatively, you may print it and then fax it to us at (650) 419-9877.