MIND REJUVENATION
Cristina Barnes, APRN

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

For Office Use Only

Date of Request _____ Date Received _____ MR/AAIC Staff _____

Name _____ DOB _____ SS# _____

Phone _____ Phone _____

Purpose _____ Spravato _____ Ketamine _____ Other

Date(s) of Records Requested _____ to _____

I am the **X** Patient _____ Guardian _____ Parent _____ Other

Records From:	Records To:
Name:	Name: **Mind Rejuvenation/AAIC**
Address:	Address: **7307 S Yale Ave. STE 200, Tulsa, OK 74136**
Phone:	Phone: **(918) 392-4550**
Fax:	Fax: **(918) 392-4551**

I would like the following information:

X Chart notes **Last 3 Office Visits** **X** List of current medications

X Depression Scores **X** List of medications that have been tried and failed

I understand:

* I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. **Unless revoked, the automatic expiration date will be six (6) months from the date of signature.**
* Unless the purpose of this authorization is to determine payment of a claim or benefits, Mind Rejuvenation/AAIC may not condition the provision of treatment or payment for my care on my signing this authorization.
* Information used to disclose under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
* THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON COMMUNICABLE DISEASE.
* The information authorized for release also may include protected health information related to mental health.
* The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____

(Signature of Patient, Parent, or Legal Representative) (Relationship to Patient) (Date)