# AUTHORIZATION TO EXCHANGE INFORMATION

Client's Name:

Date of Birth:

I hereby request and authorize Dr. Robert Grant, MD and Dr. Jessica Katzman, PsyD, to exchange confidential information obtained during the course of my ketamine assisted psychotherapy with the following party:

Name: ______________________________________________________

Email/Phone:_________________________________________________

This request and authorization applies to:

❏ Participation/attendance in psychotherapy and/or ketamine assisted psychotherapy only

❏ Mental health and substance abuse treatment (including assessment, diagnoses, treatment, medication, discharge summary)

❏ Other:

_______________________________________________________

**AUTHORIZATION**: I understand that signing this authorization is voluntary, and by signing this authorization I am amending my rights to confidentiality. I have a right to obtain a copy of this authorization. I understand that I may revoke this authorization at any time by submitting a request in writing. I understand any request for revocation will not have any effect on any actions taken prior to its submission. I understand that if the entity authorized to receive the information is not a health plan or healthcare provider, the released information may not be protected by federal privacy regulations. This authorization will not expire unless otherwise stated. I understand that this request may result in an administrative copying fee.

| ______________________________ | ______________________________ |
|---|---|
| (Client Signature) | (Date) |