HIPPA Use/Release Form

Authorization to Use/Release Protected Health Information

Please complete this form to authorize the release of protected health information to facilitate your optimal care at Sierra Ketamine Clinics, LLC

Primary Account Holder Information

Last Name	First Name		M.I.
Street Address	City	State	ZIP
E-Mail Address	Daytime (cell) Phone	SSN	

HIPAA Release (to be completed by patient/parent)

My protected health information is individually identifiable health information, including demographic information collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse, and relates to: (i) my past, present, or future physical or mental health condition; (ii) the provision of the health care to me; or (iii) the past, present or future payment for the provision of health care to me.

In accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA), I, the undersigned, grant permission to Sierra Ketamine Clinics, LLC. Permission to use and disclose protected health information (as defined in HIPAA) to the following person or persons:

☐ My PCP (please list by name)
☐ My Psychiatrist (please list by name)
☐ Other (please list by name)

Purpose of authorization: ☐ To facilitate my care ☐ Other:
Any limitations that I impose on Sierra Ketamine Clinics, LLC with respect to this authorization

are declared below:

If at any time you need to alter this release form, please contact Sierra Ketamine Clinics, LLC at 775-276-5454

Limitations of HIPAA Release (please write NONE or ONLY ABOVE if applicable):

Authorization of HIPAA Release (to be completed by patient/parent)

I understand that by granting this Release, the person who obtains this information, by any means, may disclose it to other individuals with or without my consent or the consent of Sierra Ketamine Clinics, LLC, and in so doing, the information would no longer be protected under HIPAA. I understand that my authorizing the use and disclosure of my information is not a condition of eligibility for treatment

Date	Birth date: _____/_____/_____	Date Authorization Effective Until (If no date is provided, authorization is valid until the preset timeframe frame in Nevada)
Patient's Name (please print)		Patient/Parent Signature

Note: If the person signing above is a personal representative of the named individual, please provide a copy of the document (power of attorney) granting authority to the personal representative.

☐ Power of Attorney (POA) Attached ☐ Parent/Guardian with POA

Last, First, Middle

Contact Phone Number:

Contact Email: