JH ROI 1

I, (Print First Name Last Name and Date of Birth), *

authorize Dr Heeramun/ Joyful Horizon PLLC to release and receive protected health information to:

Name of Entity or Individual: *

Address of Entity or Individual:

Phone of Entity or Individual:

Fax of Entity or Individual if known

The release of this information is concerning all dates of my treatment unless specified here: (If you want to restrict the dates of the treatment information shared, please type the specific date range here)

The release of information is limited to the following information (select all that apply): *

- ☐ Verbal communication about the patient
- ☐ All Information within the patient record
- ☐ Admission and Discharge Summaries
- ☐ Hospital Records
- ☐ Laboratory Test Results
- ☐ Progress Notes
- ☐ Consultation reports
- ☐ ketamine and/or TMS records
- ☐ Relevant billing records
- ☐ Other Test Results, including genetic test results
- ☐ Medication(s) list
- ☐ Other

If you selected "other" please specify here

This information is to be used for the purpose of

- ☐ collaboration, continuity and/or transition of care.
- ☐ Insurance Claim
- ☐ Other
- Personal Use
- Attorney Review

I authorize all information which may be contained in my medical records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing to be released unless otherwise specified here:

I understand that I can cancel this authorization at any time by sending a letter or email/electronic message to Joyful Horizon. If I do this, it will prevent any disclosures of my information after the date it is received but cannot change the fact that some information may have been disclosed before that date.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits.

I understand that once my health information is used or disclosed pursuant to the authorization, it may be subject to redisclosure or release by the receiving Party and may no longer be protected by Federal or State Law, unless protected by Federal Regulation 42 CFR Part 2 and Public Act 258 in which case it cannot be re-disclosed by the receiving Party without my written authorization. I hereby agree to indemnify and hold Dr Vineka Heeramun, and Joyful Horizon, PLLC free from any actions against them for alleged invasion of privacy, libel, slander, or defamation arising from or related to disclosure of such information.

I agree that I had a chance to review and understand the content of this form.

This authorization is valid as of the date it is signed. This authorization can be formally revoked by written letter/email/electronic message by the patient.

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PATIENT / PARENT / GUARDIAN SIGNATURE *

Printed Name: *

Date: *