The Center For
Healing Journeys
Ketamine Assisted Psychotherapy and Treatments

RELEASE OF INFORMATION
and CONSULTATION REQUEST

I give permission for the Center for Healing Journeys or its staff representative to contact and exchange medical and psychiatric information with:

My provider is:_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone:_____ **Fax:**_____

Good thru: _____ **ROI for what purpose?** _____

_____

Signature:_____**Date:**_____

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