SHALVA CLINIC
FAMILY WELLNESS CENTER

RELEASE OF MEDICAL RECORDS REQUEST

Patient Information:

Last Name: _____ First Name: _____ M.I.: _____

Maiden Name or Other Name: _____

DOB: ____/____/_____ Age: _____ Gender: ☐ M ☐ F

Address: _____

City: _____State: _____ Zip: _____

Phone: (*home)*_____ (*cell*) _____ (*work)*_____

I hearby authorize Shalva Clinic, LLC to :

☐ release information from my medical record to: ☐ obtain information from:

Physician Information:

Physician Name and/or Facility Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released as follows: (Please specify date)

☐ X-ray/Radiology Records ☐ Lab/Pathology Records ☐ Abstract/Summary

☐ All Records ☐ Progress Notes ☐ Other: _____

These records are for services provided on the following date(s): _____

Purpose of Disclosure:

☐ Changing Physicians ☐ Consultation/2nd opinion ☐ At patients request

☐ School ☐ Complementary Care ☐ Other (please specify): _____

1. I understand that this authorization will expire one year after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient may no longer be protected by privacy regulations.
4. I understand that there may be a fee for a copy of my medical record.
5. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

☐ No Mental Health ☐ No Substance Abuse Information ☐ No HIV/AIDS

_____ _____
Signature of Patient Date

_____ _____
Print Name of Patient Date

_____ _____
Parent/Legal Guardian/Authorized Person Date

Please send completed form to:

Shalva Clinic, LLC
8 Lincoln Street
Westport, CT 06880
P: (203) 916-4600
F: (203) 916-4601