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REQUEST FOR MEDICAL RECORDS

Patient First Name: _____	**Patient Last Name:** _____
Patient Date of Birth: _____	**Today's Date:** _____

I hereby authorize and request my medical and/or pain provider _____ ("referring provider") to release to **ALCOVE MENTAL HEALTH, LLC** ("evaluator") any and all medical records including but not limited to medical examination, treatment and services rendered, radiographic reports and/or films pertaining to the following listed date(s) of service:

- **Start date of records to release FROM referring provider:** _____
- **End date of records to release from referring provider:** _____
  - *Leave blank if care is ongoing.*

By signing this form, I understand that the request for exchange of information between providers is in relation to my inquiry for pre-surgical evaluation ahead of an invasive pain procedure. I authorize the two-way exchange of information between the above-named referring provider and ALCOVE MENTAL HEALTH, LLC (my requested evaluator) in order to support appropriate triage of my request and to support comprehensive evaluation procedures, if deemed appropriate and clinically necessary.

Specifically, this authorization covers the time periods and services including:

1. the referral process to Alcove Mental Health, LLC for consideration of psychological evaluation
2. if evaluation referral accepted, the assessment and feedback period of services rendered by Alcove Mental Health LLC
3. electronic transmission via HIPAA-compliant cloud storage of final evaluation report from evaluator to referring provider

This authorization will expire 1 year from date of client signature, unless revoked in writing prior.

_____ _____
Signature Date