Dr. Anahita Kalianivala, PhD
Integrative, Client-Centered Care for Chronic Pain
775-235-2406
anahita@alcovemh.com
www.alcovemh.com

REQUEST FOR MEDICAL RECORDS

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

I hereby authorize and request my provider _____ ("consulting provider") to release to **ALCOVE MENTAL HEALTH, LLC** ("treating provider") any and all medical records including but not limited to medical examination, psychological evaluation, associated treatments 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.*

This exchange of information is being requested for the purpose of:

☐ Coordination of care and treatment planning

☐ Diagnostic evaluation

☐ Other (specify): _____

If desired, please use the following space to identify specific records to be released and/or specific limitations on information released.

- Specific records TO RELEASE:

_____

- Specific LIMITATIONS on release:

_____

By signing this form, I understand that I am authorizing the two-way exchange of information between the above-named referring provider and ALCOVE MENTAL HEALTH, LLC to support my clinical care and treatment planning.

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

_____ _____

Signature Date