BEHAVIORAL HEALTHCARE CONSULTANTS, LLC
SHAILAJA SHAH, MD

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

□ I hereby authorize Shailaja Shah, MD of Behavioral healthcare consultants, LLC to **RELEASE** my **protected health information** about me to the following individuals and/or organizations including psychiatric evaluation, diagnoses, treatment history such as medications or other modalities

□ I hereby authorize Shailaja Shah, MD of Behavioral healthcare consultants, LLC to **REQUEST** my **protected health information** including medical/psychiatric history, laboratory results, reports of any neuroimaging studies, reports of medical treatments from the following individuals and/or organizations

PRIMARY CARE PHYSICIAN:
Name:_____
Address:_____
_____
Phone:_____
Fax:_____

NEUROLOGIST
Name:_____
Address_____
_____
Phone:_____
Fax:_____

OTHER SPECIALIST:
Name:_____

Address:_____
_____
Phone:_____
Fax:_____

OTHER TREATMENT PROVIDER:
Name:_____

Address:_____
_____
Phone:_____
Fax:_____

OTHER:
Name: _____
Relationship to patient: _____
Address:_____ Phone: Fax:

With reference to all of the above, I understand that this information is not to be re-released to any person or facility except as provided by law. This authorization will continue to remain in effect until termination of my treatment with Dr. Shailaja Shah unless I specify another termination date here: _____. I understand that I may revoke this authorization for release/request of information at any time. I understand, however, that any authorization for release/request of information which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. To the extent that my record includes information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I am also authorizing disclosure of such information.

X_____ _____ _____ _____
Signature of Patient or POA or Legal Guardian Date Signature of Witness Date

Print Name _____ **Print Name**_____