Authorization for Disclosure of Medical Records

Patient to Complete:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the release of my medical records in accordance with the specification listed below. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

Records Released to:

Shalem Healing, Inc | 3338 N Dr Martin Luther King Jr Drive, Milwaukee, WI 53212

Phone: 414-640-5433 | Fax: 414-502-0192

Records Released From: *(check all that apply)*

Clinic/Facility/Provider(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released:

- ▢ Complete Copy of All Records
- ▢ Lab Reports
- ▢ Allergy Records
- ▢ Immunizations Records
- ▢ Counseling Visits
- ▢ Imaging Reports
- ▢ Other _____

For the Following Dates: _____ to _____

In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to: (check all that apply)

- ▢ Mental Health
- ▢ Payment of Insurance Claims
- ▢ Legal Investigation
- ▢ Other _____

This authorization will remain in effect until the request is processed unless you specify this authorization wil be effective for an additional time period. Written consent is necessary to revoke this request.

- ▢ Additional Time Period - Specify date(s): _____
- ▢ None
- ▢ Include future records generated during the additional time period

Signature: _____ Date: _____