Center for Integrative Health, LLC
Nancy H. O'Hara, MD & Gail M. Szakacs, MD
3 Hollyhock Lane Wilton, CT 06897
Tel: 203-834-2813 Fax: 203-834-2831

Medical Release Form

Patient Name: _____
DOB: _____

☐ I, the undersigned, authorize Dr. O'Hara and/ or Dr. Szakacs to speak with other clinicians regarding my/ my child's care.

I, the undersigned, authorize the release of:

☐ **Medical File** and/or **Lab Reports** ($75 including Shipping & Handling)* – circle one or both
*There is an additional charge of $50 for expedited processing (if records are needed in less than 2 weeks time)
☐ Other (please specify) _____

From:
Dr. Nancy O'Hara and Dr. Gail Szakacs
3 Hollyhock Lane
Wilton, CT 06897

To be forwarded to (check one):

☐ Physician Name and Address:

_____
_____
_____

☐ Patient/Parent Name and Address:

_____
_____
_____

I, the undersigned, authorize the request of:

☐ Any and all medical records
☐ The following reports:

_____
_____
_____

From: (Physician Name and Address)

_____
_____
_____

To be forwarded to:
Dr. Nancy O'Hara and Dr. Gail Szakacs
3 Hollyhock Lane
Wilton, CT 06897

_____ _____

Signature **Date**