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Consultation Request Form

Consultation DUE DATE: _____
(Please allow 2wk turnaround)

Patient Name: _____ Date of Birth: _____

I hereby authorize Dr. Cantwell and his staff to obtain and disclose my health information during a consultation with the below listed Health Care Professional.

Medical Health Professional Contact Information:

- ☐ NAME/ OFFICE:_____
- ☐ PHONE: _____
- ☐ FAX:_____
- ☐ EMAIL:_____

What can/do you want discussed during the consultation?

- ☐ All Medical Records
- ☐ All Medical & Mental Health Records
- ☐ Covering the Dates: _____ to _____
- ☐ Other: _____

_____

_____

In addition to the records above would you like us to discuss information relating to (check if applicable):

- ☐ Acquired Immunodeficiency Syndrome (AIDS)
- ☐ Human Immunodeficiency Syndrome (HIV)
- ☐ Behavioral health service/psychiatric care
- ☐ Treatment for alcohol and/or drug abuse

Consult appointments you will be charged one half your normal hourly office appointment rate. By signing this release you agree to the charges and they will automatically be charged to your credit card on file.

Dr. Cantwell and his employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to extent indicated and authorized herein signed:

Patient/or Legal Representative: _____ Date: _____

Relationship to Patient: _____ Date: _____

Signature of Witness: _____ Date: _____