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[ClientName]

REQUEST FOR MEDICAL RECORDS

Patient Information:

Full Name:

Date of Birth:

Phone Number:

Address:

I am requesting a copy of my medical/mental health records from:

Provider/Facility Name:

Provider/Facility Address:

Provider/Facility Phone Number:

Provider/Facility Fax Number:

Records Requested (check all that apply):

Entire medical record Visit notes/progress notes Medication history Test results/labs

Billing records Other: _____

Purpose of Request (optional):

Personal use Continuity of care Legal purposes Other: _____

Acknowledgement:

I hereby authorize and request the release of my records to **Tide and Branch Psychiatry, LLC** from the provider/facility listed above. I understand that I may revoke this request in writing at any time before the records are released. I also acknowledge that fees may apply for the reproduction of medical records in accordance with state and federal law.

PATIENT OR LEGAL GUARDIAN Signature

Date