[Your Name]
[Your Address]
[Your Phone Number]
[Your Email Address]
[Date]

[Recipient Name or Medical Records Department]
[Name of Psychiatric Facility/Clinic]
[Clinic Address]

RE: Request for Psychiatric Medical Records

Patient Name: [Full Name]
Date of Birth: [MM/DD/YYYY]
Patient ID/Account Number (if known): [ID Number]

To whom it may concern,

I am writing to formally request a copy of my psychiatric medical records for the purpose of a specialist consultation. Please provide records covering the period from [Start Date] to [End Date].

Specifically, I am requesting the following documents:

- Psychiatric evaluations and intake assessments
- Clinical progress notes
- Treatment plans and summaries
- Medication history and prescription records
- Diagnostic test results (if applicable)
- Discharge summaries (if applicable)

Please deliver these records via the following method:

[Secure Email Address / Physical Mailing Address / Patient Portal]

I understand that there may be a fee for copying or processing these records. Please notify me in advance if the cost exceeds [Insert Dollar Amount].

I have attached a signed authorization form to this request. If you require any further information, please contact me at [Your Phone Number].

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]