

**Date:** [Date]

**To:** [Recipient Provider/Facility Name]

**Address:** [Recipient Address]

**Phone:** [Recipient Phone Number]

**Fax:** [Recipient Fax Number]

**RE: REQUEST FOR PSYCHIATRIC RECORDS**

**Patient Name:** [Patient Full Name]

**Date of Birth:** [Patient DOB]

**SSN (Optional):** [Patient SSN]

Dear [Provider Name or Medical Records Department],

The above-named patient is currently under my care for psychiatric treatment. To ensure continuity of care and comprehensive treatment planning, I am requesting a copy of the patient's psychiatric medical records from your facility.

**Please include the following information from [Start Date] to [End Date]:**

- Psychiatric evaluations and intake summaries
- Progress notes and psychotherapy notes
- Medication history and current MAR
- Laboratory results and toxicology reports
- Discharge summaries (if applicable)
- Treatment plans

Attached to this request is a signed Authorization for Release of Information (ROI) compliant with HIPAA and 42 CFR Part 2 regulations.

Please fax these records to **[Your Fax Number]** or mail them to the address listed below:

[Your Name/Practice Name]

[Your Address]

[Your City, State, Zip Code]

[Your Phone Number]

Thank you for your prompt assistance in this matter.

Sincerely,

[Your Signature]

[Your Printed Name and Title]