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

[Date]

[Name of Doctor or Medical Facility]
[Department, if applicable]
[Facility Address]

RE: Request for Psychiatric Treatment History
Patient Name: [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Patient ID/Account Number: [If known]

To Whom It May Concern,

I am writing to formally request a copy of my psychiatric treatment history and medical records maintained by your facility.

Please include the following information in the records provided:

- Dates of treatment and attendance
- Diagnoses
- Medication history and prescriptions
- Treatment plans and summaries
- Discharge summaries (if applicable)
- Clinical notes

I am requesting these records for the purpose of [State reason, e.g., continuity of care, personal records, or legal proceedings].

I have attached a signed authorization form for the release of information as required by HIPAA or local privacy regulations. Please inform me if there are any processing fees associated with this request so that I may provide payment promptly.

Please send the records to:
[Recipient Name/Organization]
[Delivery Address or Secure Email Address]

If you are unable to fulfill this request or require further information, please contact me at [Your Phone Number].

Thank you for your assistance.

Sincerely,

[Your Signature]

[Your Printed Name]