Date: [Date]

To:
[Provider/Facility Name]
[Out-of-State Address]
[City, State, Zip Code]
Fax/Phone: [Provider Fax/Phone Number]

Re: Patient Information
Patient Name: [Patient Full Name]
Date of Birth: [Date of Birth]
Last 4 of SSN: [Optional: Last 4 digits]
Treatment Dates: [Approximate Dates of Service]

To Whom It May Concern,

I am writing to formally request a copy of the psychiatric medical records for the above-named patient. I am making this request for the purpose of [Reason: e.g., continuing care, legal proceedings, personal records].

Please provide the following records:

- Psychiatric Evaluations and Intake Assessments
- Progress Notes and Session Summaries
- Medication Management Records and Current Medications
- Treatment Plans and Discharge Summaries
- Laboratory and Diagnostic Test Results

Attached to this letter is a signed HIPAA-compliant Authorization for Release of Information (ROI) form, which permits you to release these records to me.

Please deliver these records via the following method:

[ ] **Secure Email:** [Email Address]
[ ] **Fax:** [Fax Number]
[ ] **Mail:** [Mailing Address]

If there is a fee associated with this request, please notify me in advance. If any portion of these records is withheld due to state laws or clinical sensitivity, please provide a written explanation for the denial as required by law.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Signature]
[Your Printed Name]
[Your Relationship to Patient: e.g., Self, Legal Guardian, MD]
[Your Phone Number]

Enclosure: Signed Authorization for Release of Information