LETTER OF INSTRUCTION: AUTHORIZATION TO RELEASE PSYCHIATRIC MEDICAL RECORDS

Date: [Insert Date]

To:
[Name of Facility/Provider]
[Department, e.g., Medical Records Department]
[Address]
[City, State, Zip Code]

RE: Patient Information
Patient Name: [Full Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional/Last 4 digits): [Last 4 Digits]
Phone Number: [Your Phone Number]

To Whom It May Concern,

I am writing to formally instruct and authorize the release of my protected psychiatric medical records. This authorization specifically includes information regarding mental health treatment, psychotherapy notes, and psychiatric evaluations.

1. Information to be Released:
Please provide the following records: [e.g., Complete medical file, discharge summary, treatment plans, progress notes, and medication history] for the period ranging from [Start Date] to [End Date].

2. Recipient Information:
Please send these records to:
Name/Organization: [Recipient Name]
Address: [Recipient Address]
City, State, Zip Code: [Recipient City, State, Zip]
Fax Number (if applicable): [Recipient Fax]
Email (if applicable): [Recipient Email]

3. Purpose of Release:
The records are being released for the following purpose: [e.g., Personal use, continuing care, legal matters, or insurance claim].

4. Expiration and Revocation:
This authorization will expire on [Insert Date or Event]. I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

I understand that the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I also understand that my treatment or payment for treatment cannot be conditioned on my signing this authorization.

Please contact me at [Your Phone Number] if there are any fees associated with this request or if further documentation is required.

Sincerely,

_____
[Signature of Patient or Legal Representative]

[Printed Name of Patient or Legal Representative]
[Relationship to Patient, if applicable]