Permian Psychiatry

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MEDICAL RECORD RELEASE FORM

I, _____ , give the offices of Dr. Ravi Medi authorization to obtain ( ) or release ( ) any medical information regarding _____
(Print Patient Name)

Address pertaining to the facility that is requesting or sending the medical records.

_____

_____

_____

Phone# _____ **Fax#** _____

_____ _____
Print Patient Name **Patient Date of Birth**

_____ _____
Guardian or Patient Signature **Date**

Permian Psychiatry & Associates reserves the right to charge for medical records if deemed necessary.
Make checks payable to Dr. Ravi Medi Fee: _____
Prepayment is required. Allow two weeks to process your request.