Psychiatric Medical Associates, PA
6404 International Pkwy, Suite # 1010,
Plano, TX 75093
Phone # 972-267-1988
Fax # 972-267-3434

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI) / MEDICAL RECORDS

Patient Name :_____ D.O.B. _____

I hereby authorize Psychiatric Medical Associates, PA
6404 International Parkway, Suite 1010
Plano, TX 75093

to **release/obtain** my medical records and any personal health information concerning me to / from :

Recipient's Name & Address: _____

_____

_____

Phone #_____Fax #_____

By signing below, I instruct Psychiatric Medical Associates, to release/obtain my medical records / personal health information without any restrictions to/from the above mentioned recipient. I understand that this authorization is voluntary and made at my discretion. I may cancel/revoke this authorization at any time by giving written notice of my desire to do so.

_____ _____ _____

Patient Name Patient Signature Date

Address: _____

Street City State Zip code

Signature of parent, guardian or authorized representative (if applicable) : Date