4205 W. Atlantic Blvd, Ste C Delray Beach, FL 33445 **Phone (561) 266-4450**

Website- delraybeachpsychiatry.com **Fax (561) 257-5229**

RELEASE OF MEDICAL INFORMATION

I, (Name)_____(Signature)_____

(DOB)_____ authorize Boca Raton Psychiatry to discuss all pertinent aspects of my medical and psychiatry care with the following individuals, physicians or hospitals listed below. In addition, I authorize Boca Raton Psychiatry to obtain any laboratory reports, hospital records, diagnostic imaging or medical records deemed necessary for treatment from the providers listed below.

Name_____

Location_____

Phone_____

Fax#_____

For the above named entity, please fax and/or mail any pertinent medical records, last treatment notes or reports in help in providing medical care.