Psychiatric Medical Associates, PA / NTBHA Affiliate
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 / NTBHA

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: ____

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Phone #__________________________________Fax #_________________________

By signing below, I instruct Psychiatric Medical Associates / NTBHA, 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