Request for Medical Records

Patient Name: ________________________________ **Patient DOB:** __________________

Facility:

Banyan
Banyan
Banyan
Banyan Seabring

Banyan
Banyan
Banyan P
Banyan Alaska

Banyan
Banyan
ehavioral Health of the Palm Beaches (B)
Banyan Gulfbreeze

Method of transmission:

Mail

Fax

Address: ____
City: ________________________ State: ____ Zip: _________
Email: ____

Reason for Release of Information: ____

Information to be released (Check all items that apply):

Bio-psychosocial
Psychiatric Evaluation
Laboratory Reports

Treatment Plans & Reviews
Discharge Summary

Attachments

In order to authenticate this r

______________________________ ______________________
Patient Signature Date