MEDICAL RECORDS RELEASE FORM

Organization: _____

Attention: _____

Phone #: (_____) _____-_____, **Fax #:** (_____) _____-_____

I request that the following information to be released to MP LLC:

☐**Psychiatric Evaluation** ☐**Psychiatric Progress Notes** ☐**Physical Examination**
☐**Medical Progress Notes** ☐**Consultation Notes** ☐**Psychotherapy Notes**
☐**Laboratory Results** ☐**ECG/EKG Results** ☐**Diagnostic Results** ☐**Other**
_____

☐**All other pertinent information related to my medical and/or psychiatric health**

I authorized you to release my medical records to:

Metamorphosis Psyche LLC
Attn: Dr. Celeste Boyd
6101 West Atlantic Blvd., Suite 202, Margate, Florida 33063
Phone: (954) 906-4106 / Fax: (954) 906-4029
Email: cbadmin@metamorphosispsyche.com

Patient Name: _____

Patient Signature: _____

Date of Birth: _____/_____/_____

Date: _____