LIGHTHOUSE PSYCHIATRY ADVANCED TMS THERAPY AND RESEARCH
Tel: (480) 565-6440 Fax: (480) 454-1085 TMS@LHpsych.com 4001 E Baseline Rd Ste B-7, Gilbert AZ 85234
www.LHpsych.com www.LighthouseTMS.com

Request for Medical Records

By signing this form, I, the patient, authorize release of my confidential health information, including a copy of my medical records, or a summary or narrative of my protected health information, **TO and FROM** the physician, person or facility listed below allowing effective coordination of care.

Patient Name: Date of Birth:

Patient Address:

Name of Physician/Person/Facility:

Address:

Contact Information:

Subject to this signed release form, the information allowed released includes the following:

- HISTORY & PHYSICAL
- PROGRESS NOTES
- CARE PLAN
- LAB REPORTS
- RADIOLOGY REPORTS
- TREATMENT RECORD
- HOSPITAL REPORTS
- MEDICATION RECORD

Subject to this signed release form, I understand my protected health information will be used to communicate with whose authorized and directly associated in my medical care:

The purpose/reason for this release of information includes the following:

- CONTINUATION OF CARE
- PERSONAL REASONS
- INSURANCE
- LEGAL

Patient/Guardian Signature Date

Guardian Name and Relationship (if applicable)