Gladstone
Psychiatry and Wellness

Request to Release Records

Patient Name: _____ **Patient Date of Birth:** _____

I , _____, hereby request and authorize Gladstone Psychiatry and Wellness to release the following records:

☐ All Records
☐ All Medication Management Records (Intake and Progress Notes)
☐ All Therapy Records (Group and Individual)
☐ Other: _____

Release Records To:

Name: _____

Relationship to Patient:

☐ Self
☐ Family Member
☐ Medical Provider
☐ Insurance
☐ Law Office
☐ Employer / School
☐ Other: _____

Send Records By:

☐ Fax: _____
☐ E-mail: _____
☐ Other: _____

This request and authorization applies to:

☐ From start of treatment to current date
☐ From: _____ (Start Date) to _____ (End Date)

By signing this form, you are authorizing the release of any pertinent healthcare information and records regarding drug, alcohol, or mental health treatment to the person/entity listed above. This release is valid for up to 180 days after discharge from Gladstone Psychiatry and Wellness.

Please note that this form is only to request that records be sent. The provider cannot communicate verbally or exchange any additional information with the aforementioned entity unless a “Release of Information” form is also signed.

Signature: _____ **Date:** _____

Relationship to Patient (If Applicable) : _____