



Fayetteville Psychiatry

*· compassionate care ·
· evidence-based treatment ·*

REQUEST FOR RELEASE OF MEDICAL RECORDS/NOTES

FAX 844 777 6299

Date: _____

To: Fayetteville Psychiatry

Fayetteville AR 72701

I, _____ hereby request that my medical records/notes be released FROM
Fayetteville Psychiatry, Ltd., TO:

_____ Phone _____

Physician name/practice (print)

Address

City

State

Zip

Printed Name: _____

Signature and Date: _____