Psychodynamic Psychiatry, PLLC
Dhipthi Brundage, M.D.
3001 Academy Road, Suite 240
Durham, NC 27707

Phone: 919.972.8640
Fax: 919.375.3961

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: Date of Birth:

I am requesting information/records to be released, communicated and/or sent to Dhipthi Brundage, M.D. at Psychodynamic Psychiatry, PLLC. This is being requested for the purpose of ongoing treatment.

1. I am making this request to the following person or organization:

Person or Organization Name:		
Street Address:		
City:	State:	Zip:
Phone:	Fax:	

2. The specific protected health information I am requesting to be disclosed is:

- o Progress/Treatment Notes
- o Records Related to Substance Abuse
- o Laboratory Results
- o Diagnostic Imaging Reports
- o Admission History & Physical
- o Discharge Summary
- o Psychological Testing
- o Other

Dates of Treatment From: To:

3. I understand that information and records sent to Psychodynamic Psychiatry, PLLC will be incorporated into my medical record and become part of my protected health information. This authorization will expire on _____, or in one year from the date of the signature below if no date is indicated, or sooner if I revoke this authorization in writing. I understand that I am not required to sign this form.

Signature: Date