Medical Record Release Authorization

To: _____
Address: _____
_____
Phone number: _____
Fax: _____

I _____ hereby authorize and request you to release to:
Altahir Behavioral Health PLC/ Ali Altahir, MD

6319 Castle Place
Suite 2A
Falls Church, VA 22044
Phone: 703-738-3459
Fax: 703-468-1381

239 Garrisonville Rd
Suite 201
Stafford, VA 22554
Phone: 703-373-7338
Fax: 703-468-1381

The complete mental health/medical records in your possession, concerning my illness and/or treatment.

Patient's name: _____
Date of birth: _____
Address: _____
Patient's/Guardian name: _____
Patient's/Guardian Signature: _____ Date: _____