MICHAEL T. INGRAM, JR., M.D., M.S.

M.T.I. PSYCHIATRY, INC.

RELEASE OF INFORMATION FORM

PATIENT FULL NAME (FIRST, MIDDLE, LAST) **PATIENT DATE OF BIRTH**

PATIENT HOME ADDRESS **PATIENT PHONE NUMBER**

I GIVE DR MICHAEL INGRAM PERMISSION TO DISCUSS MY MEDICAL AND MENTAL HEALTH HISTORY WITH THE FOLLOWING INDIVIDUALS/INSTITUTIONS. IN ADDITION, I GIVE THE FOLLOWING INDIVIDUALS/INSTITUTIONS PERMISSION TO RELEASE MY MEDICAL AND/OR MENTAL HEALTH RECORDS TO DR MICHAEL T INGRAM. EXAMPLES INCLUDE PREVIOUS PSYCHIATRISTS, CURRENT THERAPIST, PRIMARY CARE PROVIDER, OTHER HEALTHCARE PROVIDERS, FAMILY MEMBERS, FRIENDS, ETC. (If none, write NONE):

By signing your name in the space provided, you are giving Dr. Michael T Ingram, Jr. permission to contact the above-named individuals/institutions for the purpose of discussing and/or obtaining your mental health history, lab/imaging results, and medical history. You understand that this form is valid until you specifically state in writing that you no longer give Dr. Michael T. Ingram, Jr. permission to do the above.

PATIENT OR LEGAL GUARDIAN NAME (PRINT)

PATIENT | LEGAL GUARDIAN SIGNATURE **DATE**

8271 MELROSE AVENUE, SUITE 110, LOS ANGELES, CA 90046 PHONE: (949) 436 – 9099 FAX: (475) 313 - 1260
WEBSITE: WWW.MICHAELTINGRAM.COM EMAIL: MINGRAM@MTIPSYCHIATRY.COM