ADULT PSYCHIATRY
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Latasha Matthews, PMH, NP

CHILD/ADOLESCENT PSYCHIATRY
David W. Gould, III, M.D.
Charles E. Hall, IV, M.D.

CLINICAL THERAPY
Catherine B. Thorne, Ph.D., L.C.S.W.
Kathi K. Anderson, L.P.C.
Philip M. Campbell, M.F.T.

Ann M. Rawls, C.O.O.

Tucker Psychiatric Clinic, Inc.

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Records Request Authorization

PLEASE PRINT
Patient's Name_____
Patient's Date of Birth_____
Patient's Phone Number_____

I hereby request and authorize you to:
_____release the complete medical records in your possession
and/or
_____discuss care and treatment of the above patient as follows:

FROM/TO:

_____
_____
_____
_____
Fax:_____

FROM/TO:

Provider:_____
Tucker Psychiatric Clinic, Inc.
1000 Boulders Parkway, Suite 202
North Chesterfield, VA 23225
Fax: (804) 320-2050

Please list the date range of records your are requesting:_____

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Signature of Patient or Legal Guardian Date

Once complete, please email to: records@tuckerpsychiatric.com
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