ANDOVER PEDIATRICS, P.C.
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AS YOU COMPLETE EACH STEP ON THE FORM, PLEASE MAKE A CHECK MARK IN THE BOX PROVIDED AT LEFT.

Step 1 Completed ☐	**STEP 1:** Information about you: **PLEASE PRINT!!!** PATIENT NAME: _____ DATE OF BIRTH: _____ Last First ADDRESS: _____ Street City State Zip
Step 2 Completed ☐	**STEP 2:** To whom do you wish to release your records? **PLEASE PRINT!!!** To release the following information: Please specify: ❑ ALL RECORDS OR ❑ Dates of Treatment: _____ TO: _____ OTHER: _____ To: _____ _____ _____
Step 3 Completed ☐	**STEP 3:** Your Signature: This authorization is valid from 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required. _____ Patient's Signature _____ Witness Signature _____ Parent/Guardian's Signature
Step 4 Completed ☐	**STEP 4:** Release for Sensitive Information I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE. _____ Signature of Patient or Legal Guardian _____ Date
Step 5 Completed ☐	**STEP 5:** Release of HIV Information IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/ TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW. **I AGREE TO THE RELEASE OF THIS INFORMATION.** _____ Signature of Patient or Legal Guardian _____ Date

There will be a $10 charge for records copied which were from a previous physician or if duplicate copies are required. Please mail payment and form so we may prepare your records.

Do you want these records copied? _____Yes _____No