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AUTHORIZATION TO RELEASE MEDICAL RECORDS

You have requested that Andover Pediatrics PC, release your or your child's medical records.

- A separate Records Release Form must be completed for each patient.
- There is a processing fee of **\$10.00** for each record. The signed form and fee must be received before medical records are processed.
- If the patient is age 18 or over, they must fill out and sign the release. If you allow another person to pick up your records, you must print their name on the release below.
- Records may be picked up in the office or mailed home (note below).
- Any records that are not picked up will be disposed of. Any duplicate copies will be an additional \$10.00 charge.

Please Print

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Telephone:** _____

Check one: _____ mail records home _____ pick up records in office

If someone other than the patient will pick up the records, list who is authorized to receive them:

Name: _____

I understand that my medical record may contain information regarding Aids, STD-related information, drug & alcohol abuse, psychiatric, and sensitive information. I agree to release of this information.

Patient/Legal Guardian Signature

Date

For office use: \$10 Fee paid by: _____ cash _____ check _____ credit card