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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. Complete **BOTH** pages and **SIGN** page 2.
- There is a processing fee of **\$10.00** for each **Complete Medical History** record. A Complete Medical History will be saved on a USB drive, and can be mailed to your home or to the new PCP office. This file is too large to email.
- There is **no fee** if your request is for only the **Immunizations & Most Recent Physical**. The Immunizations & Most Recent Physical **ONLY** option can be printed and mailed to your home or to the new PCP office, or sent to you electronically by secure email.
- 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.
- Any duplicate copies will be an additional \$10.00 charge.

PLEASE PRINT

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

Address: _____ **Telephone:** _____

Email Address: _____

Check Option A or B, and the delivery preference below:

A. _____ **Complete Medical History (\$10)**

_____ Mail records home

_____ Mail records new PCP office

or

B. _____ **Immunizations & Most Recent Physical Only (no fee)**

_____ Mail records home

_____ Mail records new PCP office

_____ Secure Email

Continued on Page 2

New PCP Name: _____

Name of Practice: _____

Address: _____

Phone: _____

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