



# CHILDREN'S MEDICAL OFFICE

of North Andover, P.C.

477 Andover Street  
North Andover, Massachusetts 01845

www.chmed.com  
978.975.3355

## Request For Medical Records

Date: \_\_\_\_\_

To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Fill in complete name and address of prior  
physician or health care facility)

I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to the patient named below during the time period from \_\_\_\_\_ to \_\_\_\_\_ and request that you forward the information to:

**CHILDREN'S MEDICAL OFFICE OF NORTH ANDOVER, P.C.  
477 Andover Street  
North Andover, MA 01845**

\_\_\_\_\_  
**Patient's Name**

\_\_\_\_\_  
**Signature of patient/ legal guardian if patient is a minor**

\_\_\_\_\_  
**Patient's Address**

\_\_\_\_\_  
**Relationship of signer to patient if other than self**

\_\_\_\_\_  
**Patient's Date of Birth**

### RE-RELEASE AUTHORIZATION

The above request applies only to records of care rendered by the addressee. Federal and state regulations require specific separate authorization for the "re-release" of records from other professionals or facilities which may be in your possession. Accordingly, I further authorize you to RE-RELEASE to Children's Medical Office of North Andover, P.C. records from each of the following physician's/facilities specifically named and signed for below:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Physicians/Hospitals/Other Facilities

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorizing signature

### RELEASE OF SENSITIVE INFORMATION

The above request does not apply to certain types of "sensitive" information. By law, information pertaining to any of the following subjects should be withheld or deleted from the record unless specific separate authorization is given to disclose it. Accordingly, I hereby authorize the disclosure to Children's Medical office of North Andover, P.C information pertaining ONLY to the subjects indicated by my checking "yes" below:

	<u>Disclose?</u>	
HIV/AIDS status.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological/Mental Health.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy/Sexual Activity.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\_\_\_\_\_  
Authorizing Signature