FAMILY COUNSELING ASSOCIATES OF ANDOVER

12 Essex Street | Andover, MA 01810 | Fax: 978-296-3460

RECORD REQUEST FORM

Patient Name: _____ **Patient DOB**: _____

I hereby request a copy of my mental health record as detailed below:

- □ Full mental health record held by this office
- □ Mental health record from the period_____ through_____
- □ A specific portion / selection of the record described below:

_____

_____

In keeping with Family Counseling Associates of Andover's **Notice of Privacy Policy Practices**, a reasonable charge is assessed for all record requests. There is a $15 flat fee to cover copying and processing costs.

Please Choose One of the Following:

- □ Please fax record to: _____
- □ Please send via encrypted email to: _____
- □ I will pick up my record in person
- □ Please mail my record to:

_____

_____

_____

Your records will be ready in 5 business days after you have submitted your request.

Signature of patient (or parent / guardian):_____

Date:_____