GENERAL PSYCHOLOGICAL ASSOCIATES

3 Dundee Park, Suite 203 – Andover, MA 01810
Ph 978 475-3590 Fax 978 475-7620

PATIENT RECORD REQUEST

Patient Name: _____ Date of Birth: _____

If patient is a minor, name of parent or legal guardian: _____
Please Print

_____ _____
Signature of Patient (If a minor, signature of parent or legal guardian) Date

- o Full medical record held by this office
- o Medical record for the period _____ through _____
- o Specific portion/section of the record as follows:

_____
_____

PLEASE CHOOSE ONE OF THE FOLLOWING

- o I would like to pick up a copy of my medical records as detailed above.

OR

- o Please mail a copy of my medical record to the following professional provider:

_____
_____
_____

REV. 7/23