

# Mendon Pediatrics, PLLC

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

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

I (parent/guardian/or patient over 18) \_\_\_\_\_  
hereby request that you release all records except (check applicable items)  
( ) HIV/AIDS information, ( ) Drug/Alcohol information, ( ) Mental Health information,  
( ) Other \_\_\_\_\_, ( ) Withhold Other Select Items (please  
specify) \_\_\_\_\_

**OR** ( ) Please release ALL records including HIV/AIDS, Drug/Alcohol and Mental  
Health Information.

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

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

Signature of Parent/Guardian/Patient \_\_\_\_\_

Copies mailed \_\_\_\_\_ (date)

Copies picked up \_\_\_\_\_