Newton-Wellesley Family Pediatrics
Boston Children's
Primary Care Alliance

617-965-6700 | *fax* 617-965-5239

Medical Records Release

Date: _____

Who filled out form: _____

I request that Newton-Wellesley Family Pediatrics release the medical records for the following patient(s):

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Reason for leaving practice:

_____

_____

Records

❍ I will be picking up the records

❍ Please mail the records to address below:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

If you are moving please update your new address in case we need to send additional information.

PLEASE NOTE:

- We only copy records from our practice not sub specialists.
- There is a $25.00 administrative fee for copying the records. Please allow two weeks at least to receive or pick up records after making the request.

Signature

Parent/Legal guardian, or patient if 18 or older:

_____