Newton-Wellesley *Family* Pediatrics, P.C.
2000 Washington Street
Suite 468
Newton, MA 02465
Tel. (617) 965-6700 Fax. (617) 965-5239

Medical Records Release Form

Date: ______________________ Who filled out form:_______________________

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

NAME (S) ____

____

DATE (S) OF BIRTH ____

Reason for leaving practice____

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I will be: _________ picking up the records.

_________ Please mail the records to address below:

NAME ____

ADDRESS ____

CITY/STATE/ZIP _________________________________

PHONE NUMBER ________________________________

If you are moving please update your new address in case we need to send additional information
We only copy records from our practice not sub specialists.

****PLEASE NOTE:** *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 (18 yrs. Old)