

Received

# PATIENT RECORD ACCESS REQUEST FORM

Worcester Pediatrics, P.C.  
123 Summer St., Suite 690  
Worcester, MA 01608  
Phone: 508-363-9530 Fax: 774-843-5498

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

Electronic medical record held by this office. \* \$15.00

(We Do Not provide copies of records, which were forwarded to our office. These records should be requested from the original source.)

I AGREE TO PAY THIS CHARGE IN FULL AT THE TIME I REQUEST THE COPY OF THE RECORD.

★ If 18 year or older patient must sign for medical records!

Patient Name:		DOB:	
Name:		Relationship:	
★ Signature:		Date:	

Please mail records to:

Physician Name:
Address:

This form must be mailed back with appropriate payment for each record requested. **Faxed requests will not be honored - without payment.** Once records have been copied, they are sent to an off site storage facility. Due to this process we cannot access your child's medical record easily. There is a charge for record retrieval from the storage facility