Received

PATIENT RECORD ACCESS REQUEST FORM

Worcester Pediatrics, P.C.
123 Summer St., Suite 690N
Worcester, MA 01608
Phone: 508-363-9530 Fax: 833-428-4030

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

☐ Electronic medical record held by this office. * $25.00
(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.**