PATIENT UNDER 18

Authorization for Release of Medical Records

Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

ashenbergpedi.com
978-957-4300 | *fax* 978-957-3891

To whom it may concern:

I am requesting a copy of my child's medical record for when he/she was seen at your facility on or around:

Date: _____

to be mailed or faxed to:

Alena Ashenberg, MD Pediatrics
505 Nashua Road, Suite 5
Dracut, MA 01826
Fax: 978-957-3891

Patient name: _____

Date of birth: _____

Parent/Guardian name: _____

Parent/Guardian signature: _____

Date: _____

If you have any questions, you may contact their office. Thank you for your assistance.