

ALENA ASHENBERG, MD PEDIATRICS, LLC
505 Nashua Road, Suite 5
Dracut, MA 01826
PHONE (978) 957-4300
FAX (978) 957-3891

Today's Date: _____

To Whom It May Concern:

I am requesting a copy of my medical record for when I was seen at your facility on
or around _____ to be mailed or faxed to my physician. My

name is _____, date of birth _____.

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

Sincerely,

Patient Signature

Print Name