PATIENT 18 OR OVER

Authorization for Release of Medical Records

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

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978-957-4300 | *fax* 978-957-3891

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:

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: ____

Patient signature: ____

Date: ____

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