Porter Pediatrics
354 Tremont Street, Boston, MA
Tel #: (617) 426 9200
Fax #: (617) 426 9201

# Request for Medical Records

**To:** **Name** ______________________________

**Street** ______________________________

**City / Zip** ______________________________

**Fax** ______________________________

**Re:** **Patient Name** ______________________________

**DOB** ______________________________

The above patient is under the care of ________________________ MD in our office. Please forward the following information as soon as possible:

- Complete medical record
- Summary
- Immunization records
- Lab data (specify: ___________________)
- Allergy records
- Medical imaging (specify: __________________)
- Eye care records
- Other (specify: _______________________)

- Time period: __________________________

I hereby authorize ___________________________ to furnish the above requested information contained in my child's medical record to Porter Pediatrics.

____________________________________ __________________________

**(Signature, Parent or Guardian)** **(Date)**