354 Tremont St
Boston, MA 02116
Phone: 617-426-9200
Fax: 617-426-9201
www.porterpeds.com

REQUEST FOR MEDICAL RECORDS

Patient Name: _____ DOB ___/___/____

Address: _____

City: _____ State: _____ Zip Code: _____

Please forward the following medical records (check all that apply)
_____ Complete medical record -OR-
_____ Office Visit Notes
_____ Immunization records
_____ Labs
_____ Other (please specify) _____
_____ Specific Time Period (please specify) _____

I hereby authorize Porter Pediatrics to fax or mail the above requested medical records to:

Name of Practice: _____

Name of Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Effective September 1, 2021: A $25 fee will be charged for medical records picked up by the patient/parent/legal guardian or mailed to the patient/parent/legal guardian.

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