Porter Pediatrics
Comprehensive Pediatric Health Care, PC

354 Tremont St
Boston, MA 02116
TEL: 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 November 1, 2022: A $50 fee will be charged for medical records picked up by the patient/parent/legal guardian or mailed to the patient/parent/legal guardian.

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_____ _____

Signature (Parent/Guardian) Date