LYNNFIELD PEDIATRICS
628 Salem Street
Lynnfield, MA 01940
Tel: 781-599-1998
www.lynnfieldpediatrics.com

RECORDS RELEASE FORM

Date needed by: _____

Today's Date: _____
(THIS FORM WILL EXPIRE ONE YEAR FROM THE ABOVE DATE)

Name of Patient (please print full name): _____

Patient's address: _____

Patient's date of birth: _____

Name of person requesting records transfer: _____

Relationship to patient: _____

Phone number where you can be reached for questions: _____

The records will be SENT FROM:

Name: Ruth Hazen, M.D. / John Schey, M.D. Facility: Lynnfield Pediatrics

Address: 628 Salem Street Phone: 781-599-1998

City, State, Zip: Lynnfield, MA 01940 Fax: 781-599-1221

The records will be SENT TO:

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax: _____

What information do you want sent? Please check the appropiate boxes.

☐ Summary of records ☐ From: _____ To: _____
☐ Complete records ($15 charge may apply)
☐ Other: _____

Reason for records:

☐ Transferring care ☐ Personal reasons ☐ Moving
☐ Other: _____

Signature of Patient: _____ Date: _____

Signature of Witness: _____