Bartlett Pond Family Medicine, P.O. Box 104, Berlin, MA 01503

I, ____ Authorize release of (check one):

______ My medical records: ____
Date of Birth

______ My child's medical records: ____
Child's Name Child's Date of Birth

Choose one and fill out the relevant information below.

Important: Any additional requests for medical records must be obtained from your new provider! Once records are transferred we are not required by law to retain them.

______ Myself (choose one option below)

_______ Send the medical record via fax to my new medical office.
There is a $10 fee for this service.

_______ Mail a digital PDF copy to me by certified mail. Paper copies are not available. The PDF can be printed from a computer or given to your new medical office.)
There is a $15 fee for this service.

Your mailing address: ____

Your telephone number: ____

______ The following medical office:

Name of Medical Office: ____

Medical Office Address: ____

Medical Office Tel #: ____

Medical Office Fax #: ____

The fax and telephone numbers are required--we cannot process the release without them!!

Please include your check or money order payable to Bartlett Pond Family Medicine. Forms sent without payment will not be processed! Mail this form and the payment to Bartlett Pond Family Medicine, P.O. Box 104, Berlin, MA, 01503.

Your Signature **Your Printed Name** **Today's Date**