Pediatric Gastroenterology and Nutrition Group, P.C.
Request for Medical Records

_____ _____
Patient's Name Patient's Date of Birth

I hereby request and authorize Pediatric Gastroenterology and Nutrition Group, P.C., to release the information specified below to the organization, or individual named in this request.

_____
Name, Address and Telephone Number of the organization to **receive** information (please include the specific Department/Individual to receive the records)

_____
Purpose(s) of Request (Continuing Care, Insurance, Legal, Personal, etc…)

_____
Preferred Delivery Method (Mailed or Faxed). If documents are to be faxed, please include the (verified) Fax Number.

_____
Date Records Required By

_____
Unless otherwise stated above, information to be disclosed will include: Labs, Radiographic Studies, Procedure Studies and Consult Letters.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient or Authorized Representative Relationship to Patient

This form may be mailed or faxed to:
Pediatric Gastroenterology and Nutrition Group, P.C.
3640 Main Street, Suite 204
Springfield, MA 01107

Fax (413) 304-2649