South Cove Community Health Center

Medical Record Certification

I, _________________________, am an authorized custodian of medical records for South Cove Community Health Center, located at 145 South Street, Boston MA 02111.

I certify that:

- The attached record is a true copy of the medical record for:

  Patient Name: ___________________________

  DOB: ___________________________

- The attached record comprised of ______ page(s) includes:

  ____

  ____

  ____

  ____

  ____

- Said record was made in the regular course of business of South Cove Community Health Center.

____
Signature

____
Printed Name

____
Title

____
Date