South Cove Community Health Center
145 South Street
Boston, MA 02111
617-457-6617 617-457-6600(fax)

Date: _____ **Regarding: Medical Record Disclosure**

Patient Name: _____

DOB: _____

To: _____

_____

_____

Fold Here

Please be advised that charges for releasing the above patient's medical records is: _____.

Please make check payable to:

South Cove Community Health Center
Medical Records Department
145 South Street
Boston MA 02111

Records will be sent upon receipt of payment.
Please return this form with payment.

Thank you.

South Cove Community Health Center

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