

**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: _____

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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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