

OB Medical Record Release Form

To request a copy (or copies*) of your medical record please complete this form and include the required information.

Medical records are mailed to a patient within seven (7) to ten (10) business days from the date of receipt of this completed request form. **The first copy of a patient's medical record is released free of charge.**

*** A fee of 25 cents per page, payable in advance, is charged for additional copies.**

Questions? Please contact the Medical Records Department. Phone (781) 674-1202 • Fax (781) 674-1520

Date _____ Patient Name _____ Patient Signature _____

Date of Birth ____/____/____ Social Security # _____
MM DD YYYY

Partner/Spouse Name _____ Signature _____

Date of Birth ____/____/____ Social Security # _____
MM DD YYYY

Where shall we send your first medical record copy for which there is no fee? CHECK ONE BOX BELOW.

Note: A letter summarizing the treatment you've had at RSC and your pregnancy test results (including a copy of your OB ultrasound report and Patient Checklist) will be sent to your identified OB.

To my address

OR

To my physician's office

Patient Address: _____

Physician Name _____

City _____

Address: _____

State _____

City _____

Zip Code _____

State _____ Zip Code _____

Fax Number _____

Reason for Request _____

Note: RSC cannot release records sent to RSC from another doctor's office.

Please check box(es) below to indicate records you are requesting.

- Patient's infectious disease testing (HIV, HepB, HepC, RPR, blood type)
- Patient's Genetic Testing Patient's Rubella Patient's Varicella
- Partner/Spouse infectious disease testing (HIV, HepB, HepC, RPR, blood type)
- Partner/Spouse Genetic Testing

