

**Medical Record Release Form**

Please complete this form in its entirety and forward it to the Doctor or Hospital that you’re requesting records from.

By signing this Medical Release Form, I authorize Boston Pelvic Health & Wellness to use and/or disclose protected health information (PHI) about myself.

Patient Information:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I HEREBY AUTHORIZE AND REQUEST MY MEDICAL RECORDS BE RELASED TO:

Boston Pelvic Health & Wellness

Jyot Saini, MD

62 Walnut Street, Floor 2

Wellesley, MA 02481

Please forward the complete medical records in your possession concerning my treatment during the period from \_\_\_\_\_\_\_\_ TO \_\_\_\_\_\_\_ (insert dates)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_

Boston Pelvic Health & Wellness

62 Walnut Street, Floor 2

Wellesley, MA 02481

**Phone: 617-769-2100 Fax: 617-769-2200**