LUK, Inc.

545 Westminster Street,
Fitchburg, MA 01420

Agency-Wide

Medical Record Request Release Form

Please fill in the blanks on this form with the name of the record being requested. We need the person's D.O.B, the dates of service requested, and the services received by client.

You must provide photo I.D at the time you pick up records. If you would like records mailed, then they will be mailed to the address listed on your state issued license/I.D. If the client is an adult and does not sign, the person who does sign must prove, with written documentation, the authority to do so.

I ______________________________ am requesting to receive my LUK records for the date(s) of:

______________________ through ______________________ .

My Date of Birth is: ______________________

Signature: ____________________________________ Today's Date: ______________________

Phone Number (where you can be reached when your records are ready): ________________________________

Please list the service(s) pertaining to the records you need: ____

Please print this document, complete the document, and:
Fax to: 978-829-0398 or
Mail to: LUK, Inc.
Attn: Records
545 Westminster St.
Fitchburg, MA 01420