LUK, Inc.

545 Westminster Street,
Fitchburg, MA 01420

Agency-Wide

Medical Record Request Release Form (For Minors)

Please fill in the blanks on this form with the name of the child whose record is being requested. We will need their D.O.B, your name, your relationship to the child, the dates of service requested, and the services received.

You must provide photo I.D at the time you pick up records. If you would like them mailed, then they will be mailed to the address listed on your license/I.D. You must provide proof that you are the parent/guardian of the child whose records are being released to you.

I _____ am requesting to receive records for _____

for the date(s) of _____ through _____.

The date of birth for this client is _____.

Signature: _____ Today's Date: _____

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

Please state your relationship the client whose record is being requested: _____

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