



**HOSPITAL/CLINIC RECORDS DESTRUCTION
FAX NOTIFICATION FORM**

TO: DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY – ATTENTION: INTAKE UNIT
FAX NUMBER: 617-753-8165

FROM: Hospital/Clinic Name: _____
Address (Street): _____
Address (City/Town) _____

In accordance with 105 CMR 130.370(F) or 105 CMR 140.302(F), this is to notify the Department that, no sooner than 30 days from the date of notification, the following medical records will be destroyed:

Type of records: _____

Date range of records: _____

Date(s) of destruction: _____

As the authorized representative of the above hospital/clinic, I certify that all records to be destroyed exceed the 20 year retention period, and that the hospital/clinic and its agents and contractors will ensure that the confidentiality of medical and personal information is maintained throughout the destruction process.

Signature of Authorized Representative

Date

Name: _____

Title: _____

Email: _____

Phone: (_____) _____ - _____ Ext: _____

Additional Comments:

