

Authorization for Release of Personal Health Information



Please review each section carefully. Forms that are filled out incorrectly will not be accepted.

- Each patient must have a separate release form. Make copies as needed.
- Any patient age 18 or older must fill out and sign the form. Forms with a parent's signature will not be accepted.
- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Fellsway Pediatrics.
- This authorization will expire after 6 months.
- Medical records will take 7–10 business days to be processed.
- Medical records will be copied onto a CD. (A paper copy may be substituted if the chart is less than 10 pages, vaccine requests only or in the event our system is broken).

This request can be:

- dropped off at office
- faxed to 781-662-2284
- emailed to: karen.yarasitis@fellswaypedi.com

Patient information

Patient first name: _____

Patient last name: _____

Date of birth: _____

Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____

Zip: _____

Current PCP: Brewer Nystuen Nagpaul

Information to be released to:

CHECK ONE BOX ONLY

- Mail to the personal address above.
- Pick up the medical records.
- Mail to your new primary care physician at the following address:

Facility/ Doctor name: _____

Address: _____

City: _____ State: _____

Zip: _____

Privileged information to be released

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record).

Sexually Transmitted Infection (STI) results and/ or notes

Yes No

Alcohol and drug abuse records

Yes No

Details of mental health diagnosis and/or treatment provided by a psychiatrist, psychologist, mental health specialist

Yes No

Details of domestic violence

Yes No

Details of sexual assault counseling

Yes No

Method of payment

Please choose one option.

- Option 1** Complete medical record from first appointment to most recent \$25.00
- Option 2** 2009 records until most recent \$15.00
- Option 3** Vaccine/ shot record ONLY \$5.00

We accept:

Visa/MasterCard/Discover

Card number: _____

Exp date: _____ CVV: _____

Check mailed to:
Fellsway Pediatrics
548 Lebanon Street
Melrose, MA 02176

Signature

Guardian, or patient if over 18:

Date: _____

Printed name: _____