Fellsway Pediatrics

548 Lebanon Street Melrose, MA 02176 • www.fellswaypediatrics.com
Tel: 781-665-4364 • **Fax:** 781-662-2284

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**

1- Patient information

Patient First Name: ________________________ **Patient Last Name:** ________________________

Date of Birth: ________________________ **Phone Number:** ________________________

Street Address: ________________________ **Apt #:** ______________

City: ________________________ **State:** __________ **Zip:** ______________

Current PCP: ○ Brewer ○ Nystuen ○ Nagpaul

2- Information to be released to – CHECK ONE BOX ONLY

☐ 1- Mail to the personal address above.

☐ 2- Pick up the medical records.

☐ 3- Mail to your new primary care physician at the following address:

Facility/ Doctor Name:____

Street Address: ________________________ **Apt #:** ______________

City: ________________________ **State:** __________ **Zip:** ______________

3- 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).

- ☐ YES ☐ NO 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 mental health specialist.
- ☐ YES ☐ NO Details of domestic violence.
- ☐ YES ☐ NO Details of sexual assault counseling.

4- 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 or mail a check to the address on the top of the first page

____

Credit Card Number ***Exp Date:*** ***CVV***

5- Signature

____

Guardian Signature/ Patient Signature ***Date***

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Guardian/ Patient Printed Name