PATIENT TRANSFER

Authorization for Release of Personal Health Information

Fellsway Pediatrics
Boston Children's
Primary Care Alliance

fellswaypediatrics.com
781-665-4364 | *fax* 781-662-2284

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 USB storage device. (A paper copy may be substituted if less than 10 pages or for vaccine request only.)

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: _____