Fellsway Pediatrics
Boston Children's
Primary Care Alliance

fellswaypediatrics.com
781-665-4364

Release of Information

In order to manage your child's care we need a signed release from their current therapist. Please fill out all of the information below. Do not return this form unless each section is filled out entirely.

Each patient must have a separate release form! Please make copies as needed

Patient information:

If patient is over 18 years or older the form must be completed with their information.

Patient name: _____

Date of birth: _____

Phone: _____

Address: _____

City: _____ State:_____

Zip:_____

Information to be released from:

I, _____

(Patient name if over 18)
do hereby authorize Fellsway Pediatrics to receive my personal health information from the following persons at the location listed below:

Doctor/Facility name: _____

Office Number: _____

Fax Number: _____

Address: _____

City: _____ State:_____

Zip:_____

Information to be released to:

Fellsway Pediatrics
548 Lebanon Street, Melrose, MA 02176

Office Number: 781-665-4364
Fax Number: 781-662-2284

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

I understand that:

- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Fellsway Pediatrics.
- This authorization will expire in 6 months unless otherwise specified
- Medical records can take 7–10 business days to be mailed or ready for pick-up

Guardian signature (or patient if over 18):

_____

Date: _____

Guardian printed name (or patient if over 18):

_____

Relationship to patient: _____