Fellsway Pediatrics

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.**

E*ach patient must have a separate release form! Please make copies as needed*

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

Patient First Name: ________________________________ Patient Last Name: _________________________________

Date of Birth: __________________________________ Phone Number: ____________________________________

Address: ____

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2- Information to be released from:

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

Doctor/Facility name: ____

Office Number: ____ Fax Number: _________________________________

Address: ____

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3- Information to be released to:

Doctor/Facility name: Fellsway Pediatrics

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

Address: 548 Lebanon Street, Melrose, MA 02176

1- 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 Psychiatrist, Psychologist, Mental Health specialist

◯ YES ◯ NO Details of domestic violence

◯ YES ◯ NO Details of sexual assault counseling

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/ Patient Signature if over 18 or form will be invalid ***Date***

____ _______________________

Guardian/ Patient printed name ***Relationship to Patient***