# Fellsway Pediatrics

548 Lebanon Street, Melrose, MA 02176
**Tel:** 781-665-4364 & 781-662-2100 • **Fax:** 781-662-2284
www.fellswaypediatrics.com

**Authorization for Release of Personal Health Information**

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

**1- Patient information:** If patient is 18 years or older they must complete and sign the form.

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____

_____

**2- Information to be released to:** Please check one box

☐ Check here to mail to the personal address above.

☐ Check here to pick up the medical records.

☐ Check here to mail to your new Primary Care Physician at the following address:

_____

_____

**3- Purpose of release:**

Reason for Transfer: _____

_____

**4- 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

**5- Method of Payment**

◯ Entire medical record: ____$20.00____ ◯ Vaccine record only: ___$5.00___

- Please mail check or money order to the office: 548 Lebanon Street, Melrose MA 02176

- ◯ VISA ◯ MASTERCARD ◯ DISCOVER

_____ _____

*Credit Card Number* *Exp. Date*

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
- Your records will be copied to an electronic CD

_____ _____

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

_____ _____

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