RECORD TRANSFER RELEASE FORM

Processing fee $15.00 per record
We mail directly to family

STAFF USE: Date: _____

PAYMENT RECEIVED: YES NO

CREDIT_____ CHECK# _____ CASH_____

OK TO COPY?:_____

OK TO SEND?:_____

DEACTIVATE?: YES NO _____

Pediatrics at Newton Wellesley
2000 Washington Street • Suite 466 Green
Newton, MA 02462
Phone: 617-969-8989 Fax: 617-928-0178
Email:pnw466@gmail.com

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

PCP: _____

I, (NAME) _____ , hereby authorize Pediatrics at Newton Wellesley, P.C. to release the following information:

Please also release the records of the following patient(s) :

1._____ Birth Date: _____
2._____ Birth Date: _____
3._____ Birth Date: _____
4._____ Birth Date: _____

- ◯ All Records
- ◯ Consultation Notes
- ◯ Discharge Summary/Emergency Records
- ◯ Office Visits
- ◯ Pathology Lab Reports
- ◯ Radiology Reports (ultrasounds, x-rays, MRI, CT scans)

Dates of service for requested release:

- ◯ All Dates
- ◯ Date Range: _____ to _____

I ◯ do ◯ do not authorize release of information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

CONTINUED

Reason for Release:

- ◯ Moving out of the area
- ◯ Legal (not leaving)
- ◯ Adult MD
- ◯ Other (please specify):_____

FOR EMAIL OR FAX AND PAYING BY VISA, MASTERCARD OR DISCOVER, PLEASE CALL WITH INFORMATION

FOR MAILING AND PAYING BY VISA, MASTERCARD, OR DISCOVER, PLEASE FILL OUT BELOW:

Card Number: _____ Exp. Date _____

Amount: _____ Signature: _____

☐ By checking this box, I authorize the processing of this card as the above named card holder.

☐ IF PAYING BY CHECK, IS IT ENCLOSED?:

$_____ No. _____

Patient/Parent/Legal Guardian Signature: _____

Relationship to Patient: _____

Printed Name: _____ Date: _____