

Staff use

Payment received: Yes No Credit Check # _____ Cash
 OK to copy? OK to send? Deactivate?: Yes No



Pediatrics at Newton Wellesley, P.C.
Boston Children's
Primary Care Alliance

pedinw.org
617-969-8989 | fax 617-928-0178

Medical Record Release

Today's date: _____

Patient name: _____

Date of birth: _____

Parent/Legal guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____

Work phone: _____

Email: _____

Primary care provider:

- Dr. Katy Brubaker Dr. Eileen Kramer
- Dr. Michael Elkort Dr. Tetiana Pronchick
- Dr. Brinda T. Gupta Dr. Susan Reuter
- Dr. Jackie Hsieh Dr. Qian Yuan

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

Patient 1: _____

Date of birth: _____

Patient 2: _____

Date of birth: _____

Patient 3: _____

Date of birth: _____

Patient 4: _____

Date of birth: _____

Records to be released

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

- 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 Dates from: _____ to: _____

I do I 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.

Reason for release

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

Payment

Processing fee is **\$15.00 per record** and must be paid prior to release.
We also request that all patient accounts be paid prior to releasing records.

Card number: _____

Exp. date: _____ CVV code: _____ Amount: _____

Signature: _____

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

(Credit card payments may also be made by phone: **617-969-8989**)

If paying by check, is it enclosed? Yes No

Check amount: \$ _____ Check #: _____

Delivery of records

Once processed, records will be released to the authorized recipient.

I wish to receive:

- USB drive sent via U.S. Mail
- Digital documents sent via secure email to:

Email: _____

Patient/Parent/Legal guardian signature:

Printed name: _____

Relationship to patient: _____ Date: _____

Your completed form may be returned:

- **In person**
- **MyChart message** as an attachment
- **Fax:** 617-928-0178
- **Mail:** Pediatrics at Newton Wellesley, P.C., 2000 Washington Street,
Green Bldg, Suite 466, Newton, MA 02462