Authorization for the Release of Medical Records

Wayland Pediatrics
Boston Children's
Primary Care Alliance

waylandpediatrics.com
508-358-2918 | *fax* 508-358-6054

Patient information

Last name: _____

First name: _____

Date of birth: _____

Parent/Guardian name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Primary phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Other phone: _____ ❍ Home ❍ Work ❍ Cell

Information to be disclosed

Records covering the following dates:

From: _____

To: _____

Transfer of records

Please select one of the following:

❍ **Once the records for the above patient(s) are copied in full, they will be picked up by:**

Name: _____

Relationship to patient: _____

❍ **I would like Wayland Pediatrics to release my/my child(ren)'s medical records to the following medical facility:**

Facility name: _____

Provider name: _____

Facility address: _____

City: _____ State: _____ Zip: _____

Facility phone: _____

❍ I **would like Wayland Pediatrics to mail my/my child(ren)'s medical records to my address:**

Address: _____

City: _____ State: _____ Zip: _____

PLEASE BE ADVISED

- Wayland Pediatrics is not able to fax or email records, we are only able to mail medical records to a home address or medical facility, or have the above named person pick up medical records.
- Legally, medical offices have 60 days from the date this form is signed, to produce medical records.

Behavioral health records (if applicable)

If you, or your child(ren), had office visits and/or communications with a Behavioral Health Provider, here at Wayland Pediatrics:

❍ I would **not like** to transfer any records pertaining to visits/ communication with a Behavioral Health Provider.

❍ I **would like** to have the records/communications transferred, to the above named medical facility. Once the records for the above patient are copied in full, I, will pick them up.

Name: _____

Relationship to patient: _____

Reason for transfer

❏ Age/ Adult PCP

❏ Legal (not leaving practice)

❏ Moving

❏ Other, please describe:

_____

PLEASE BE ADVISED

- There is a $15.00 administrative fee per chart, for preparing copies of records for transfer/mailing costs.
- All outstanding balances, as well as this transfer fee, must be paid in full, prior to record release.

Payment

❍ Credit/Debit card
Please call Wayland Pediatrics, at 508-358-2918, to pay by credit/debit.

❍ Check

❍ Cash

Authorization

Signature of parent/guardian, or patient if over 18:

_____

Date: _____

Printed name: _____

Relationship to patient: _____