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. Michael Elkort
❍ Dr. Brinda T. Gupta
❍ Dr. Jackie Hsieh
❍ Dr. Eileen Kramer
❍ Dr. Tetiana Pronchick
❍ Dr. Susan Reuter
❍ 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.

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: _____

Return this form at check-out or:

Email: **pnw466@gmail.com** Fax: **617-928-0178**

Mail: **Pediatrics at Newton Wellesley, P.C.**
2000 Washington Street, Green Bldg, Suite 466
Newton, MA 02462

Credit card payments may also be made by calling our office at **617-969-8989**