Medical Records Transfer Policy and Release Authorization

Chestnut Hill Pediatrics
Boston Children's
Primary Care Alliance

chestnuthillpeds.com
617-277-2541 | *fax* 617-232-9376

Patient last name:_____

First name: _____ MI: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Transfer policy

We will provide records of your child's visits to Chestnut Hill Pediatrics and specialist/consultation reports sent to us while overseeing your child's care. Records from before becoming a Chestnut Hill Pediatrics patient must be requested from your previous doctor(s).

If you transfer to another physician, we will provide a copy of your immunization record and a record of your last visit to your new physician at no charge, and within two business days. For more extensive record transfers, allow two weeks.

Fee schedule

Complete digital copy of Chestnut Hill Pediatrics medical record:

- $10 per child, plus a $3 mailing fee

Complete paper copy of Chestnut Hill Pediatrics medical record:

- $20 per child, plus a $12 mailing fee for the first envelope and $10 for each additional envelope thereafter

Retrieval of paper charts from off-site storage:

- $35 administration fee, paid in advance
- 20¢ per page scanning charge, paid after chart retrieved
- $12 mailing fee for the first envelope and $10 for each additional envelope thereafter

International mailing of complete medical record

- $30 per envelope, without tracking
- $47 per envelope, with tracking

A fee reduction or waiver may be granted based on financial hardship. Please inquire at the front desk or call 617-277-2541.

Authorization

Note: All references below to 'patient' are for the patient listed above.

I give my permission for Chestnut Hill Pediatrics to share my/the patient's medical record with the person or organization listed below. My/the patient's medical record may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

Choose one:

❍ Medical Record (except confidential information defined by Massachusetts law)

❍ Medical Record for dates from _____ to _____

❍ Only information from a certain illness or injury. Please describe:

_____

_____

Send a copy of my/the patient's medical records to:

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address _____

Phone: _____

Fax: _____

Under Massachusetts privacy laws, a separate consent is needed to share information about these topics:

- Alcohol/drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal (sexually transmitted) or other communicable disease(s)
- Results of tests for HIV/AIDS

Please initial all parts you agree to have shared.

By putting my initials by each item below I give permission for Chestnut Hill Pediatrics to share this type of information. I understand that if I do not initial the box, Chestnut Hill Pediatrics will not share this information about me/the patient's health to the person or organization listed above.

HIV test results (Specific approval required for each release request)

Specify dates: _____ _____ _____

Initial if info may be shared: _____

Genetic Screening Test Results

Specify type of test: _____

Initial if info may be shared: _____

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Alcohol and Drug Abuse Treatment Records
Protected by Federal Confidentiality Rules 42 CFR Part 2. Federal rules prohibit any further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2.

Initial if info may be shared: _____

Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC). I understand that my permission may not be required to release my mental health records for payment purposes.

Initial if info may be shared: _____

Confidential Communications with a Licensed Social Worker

Initial if info may be shared: _____

Information related to the use of alcohol, drugs, and/or tobacco

Initial if info may be shared: _____

Information related to a sexually transmitted disease, sexual activity and/or orientation

Initial if info may be shared: _____

Information related to diagnosis or treatment of pregnancy

Initial if info may be shared: _____

Information related to child abuse or neglect

Initial if info may be shared: _____

Information concerning family violence and/or Domestic Violence Victims' Counseling

Initial if info may be shared: _____

Other(s): Please list:

_____

_____

Initial if info may be shared: _____

I know I can revoke this form at any time. This means I can tell Chestnut Hill Pediatrics to stop sharing my/the patient's information. I know I cannot withdraw information that Chestnut Hill Pediatrics had shared before I told Chestnut Hill Pediatrics to stop. Chestnut Hill Pediatrics may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to Chestnut Hill Pediatrics telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to Chestnut Hill Pediatrics telling them to revoke this form.

Signature

By signing below I agree that I understand the above and voluntarily allow my/the patient's medical record to be shared.

Patient's name: _____

Parent/Legal Guardian's name (if applicable):

_____

Relationship to patient: _____

Signature of Parent /Legal Guardian /Self (if 13+):

_____

Date: _____

Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.

Reason for release (optional)

In an effort to better serve our patients, it is important for us to understand the reason that you/the patient is asking for your medical record or leaving our practice. Please choose the reason below.

❏ Sharing with outside provider for treatment purposes

❏ Transfer to an adult provider

❏ Moving away to: City: _____ State: _____

❏ Insurance change

❏ Provider(s) not in new network (network name)

❏ Tiering / higher co-pay / higher deductible cost

❏ Other, please describe:

_____

Important notice

You do not have to give permission to share these records. Chestnut Hill Pediatrics will not base your/the patient's treatment on whether or not you sign this form.

After your/the patient's medical record is shared, this information may be re-disclosed (shared) by the person or organization you listed above. This re-disclosure may not be protected by State and Federal law.

You have the right to get a copy of this signed form.