500 Franklin Village Drive, Suite 212
Franklin, MA 02038
www.fewcenter.com

Permission for Release and/or Exchange of Information

I hereby grant permission and authorize ________________________ (clinician) to exchange information regarding ______________________________________(client name) with the medical/health care and/or educators listed below. The purpose of this release is to assist in evaluation and treatment and to assure continuity of care among health care providers. This release will be valid as long as _________________ (clinician) is providing professional service to/for the above named client, unless permission is otherwise revoked. I understand that I do not have to sign this form to receive insurance benefits from the health plan to which I belong.

Name: ____

Address: _______________________________________

Email: ____

Phone: ____

Client name: ____

Signature of Client or Legal Representative/Guardian of Client: _______________________________________

Date: __________________________

_____ **I DO NOT** authorize the release of information as described above. However, I understand that if I don to allow my providers to exchange information about me (or my child), they will not be able to coordinate my care. I understand that, in an emergency situation, my providers may exchange information about me (or my child) to the extent allowed by law.

____ ________________________

Signature of Client/ Legal Representative or Guardian of Client Date