34 School Street, Suite 104
Foxboro, MA 02035
Phone: (508) 543-3411
Fax: (508) 543-9911

RELEASE OF INFORMATION

PATIENT NAME:____ **DATE OF BIRTH:**______/_____/______

ADDRESS:____ **PHONE: (_____)**____________

I, (or on behalf of) ______________________________(patient name) give permission to the individuals or organizations listed above to exchange information about my medical history. This includes any treatment related to psychological care. The purpose of this release is to allow continuity of care among my health care providers including carrying out discharge arrangements and to determine clinical eligibility for covered benefits.

Individual or Organization:____

Address: ____

____

Phone/Fax/Email: ____

If there are any limitations about the release of information, they are written here:

____

Signature of Client or Guardian:____ Date:________________

Signature of Therapist/Witness:____ Date:________________

I refuse to release information as described above.

Signature:__________________________________ Date:____________________