

THERAPY CENTER **RELEASE OF INFORMATION**

Authorization For the Release of Information

Name of Patient/Client _____ D.O.B. _____

I hereby authorize _____
(sender: person and facility)

To release any confidential information (specify: _____)

To _____

For the purpose of _____
(reason for request; how information is to be used)

I have read the above statements and voluntarily consent to this disclosure. I understand that my records are protected under the Federal Confidentiality Regulations and under the General Laws of Massachusetts, and cannot be disclosed without my written consent except as otherwise specifically provided by the law. I release my therapist, analyst or other employees from any liability arising from the release of this information to the designated recipient, provided the said release of information is done substantially in accordance with applicable law. I understand that I need not sign this consent form in order to receive treatment at this facility.

Any information received that is authorized by my consent shall not be further transferred without an additional written consent from me. (Federal regulations 42 CFR Part 2.)

I may withdraw this consent by giving written notification to the above party (sender) at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire ____ days after it is signed.

Signature of Patient/Client

Date on which consent was signed

Signature of Witness