I hereby authorize Boston Ability Center to release or request any medical or school related information as requested above.

Authorization for Release of Patient Information

Patient Last Name: ___________________________First Name: ______________________ MI:______

Street Address: ____Apt #:___

City:____State:____________________________Zip:_____

Home Telephone: (_____)____-________ Other Phone: (____)____-_________

Date of Birth:____/_____/______

Boston Ability Center has my permission to ☐ **release** ☐ **request** information of the above named patient with the facility or person(s) listed below.

(1) Name: ____

Street Address: ____Suite/Room #:___

City:_______________________________________State:_____________________Zip:_____

Telephone Number: (_____)____-________Email:____________________________________

(2) Name: ____

Street Address: ____ Suite/Room #:___

City:_______________________________________State:_____________________Zip:_____

Telephone Number: (_____)____-________ Email:____________________________________

(3) Name: ____

Street Address: ____ Suite/Room #:___

City:_______________________________________State:_____________________Zip:_____

Telephone Number: (_____)____-________ Email:____________________________________

Information will not be released without a valid signature below. I can however, cancel this authorization in writing at any time, except to the extent that the Boston Ability Center has relied on it. For example, if I cancel after the Boston Ability Center has sent requested records, the Boston Ability Center will not retrieve those records. Please notify in writing if you wish to cancel the future release of information.

____ ________

Signature of Patient (if 18 years of age or older) (Date)

____ ________

Signature of Parent or Guardian (if minor patient) (Date)

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&
10 TECH CIRCLE, NATICK, MA 01760
781.239.0100
BostonAbilityCenter.com

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