

BOSTON **A+** BILITY CENTER

MAKING FUN AND FUNCTION GO HAND IN HAND

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 <input type="checkbox"/> release <input type="checkbox"/> 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 address: _____
(2) Name: _____ Street Address: _____ Suite/Room #: _____ City: _____ State: _____ Zip: _____ Telephone Number: (____) ____-____ Email address: _____
(3) Name: _____ Street Address: _____ Suite/Room #: _____ City: _____ State: _____ Zip: _____ Telephone Number: (____) ____-____ Email address: _____

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)