BOSTON A+ ABILITY CENTER

MAKING FUN AND FUNCTION GO HAND IN HAND

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: (____)____-_____

(2) Name: _____

Street Address: _____ Suite/Room #:___

City:_____ State:_____ Zip:_____

Telephone Number: (____)____-_____

(3) Name: _____

Street Address: _____ Suite/Room #:___

City:_____ State:_____ Zip:_____

Telephone Number: (____)____-_____

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