JUDGE BAKER CHILDREN'S CENTER

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client's Name: _____

Another name by which
Client may have been known: _____

Address: _____

_____

I, _____ hereby authorize the Judge Baker Children's Center, 53 Parker Hill Ave., Boston, MA 02120, to release information to:

_____

_____

For the purpose (s) of: _____

Portion of record to be released: (check those that apply)

( ) Diagnostic evaluation
( ) Psychological test report
( ) Student Records / Transcript
( ) HIV testing or treatment
( ) Summary of contact with client
( ) Mental health treatment records
( ) Substance abuse treatment records
( ) Telephone contact

( ) Other: _____

I understand the following:

- Why the information is needed and I am satisfied that it will be held confidential.
- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.

Client's signature: _____ Date: _____

If client is a minor, legal custodian's signature: _____ Date:_____

Legal custodian's name/ Relationship to client: _____

Witness Name & Signature_____ Date:_____