Office Address: 2 Oak Street
Mashpee Commons, Mashpee, MA 02649

Mailing Address: P.O. Box 886
Mashpee, MA 02649

Authorization for Release of Confidential Information to and from Center for Family Therapy

Patient Name: _____ **DOB:** _____

I authorize _____to release all pertinent medical/clinical information as indicated below. The information may be either verbal or written and may be transmitted electronically. Photocopies of this Release should be accepted as valid as the original. This Authorization is valid up to one year. I understand that I may revoke this Authorization at any time. The Authorization includes information from ___/___/___ to ___/___/___.

Please release the information to: _____
(Name)

_____ _____
(Address) (Phone/fax)

_____ _____
(City/State/Zip) (Relationship to Client)

The purpose of this release of information is for:
□ Assessment
□ Treatment
□ Referral
□ Discharge Planning
□ Education

The information that may be released includes:
□ Complete medical records
□ Lab/Diagnostic Tests/Reports
□ Complete Mental Health/Substance Abuse Records
□ Information related to clinical treatment
□ Psychological or Neuropsychological Test Reports
□ School Records/IEP/grades/Psychoeducational assessments

It is my understanding that this information will be used solely for the purpose(s) described above. I understand that the information that I am authorizing to be released includes:

_____ Drug/Alcohol related information
_____ HIV/STDs/Hep. C Related information
_____ Sexual Assault/ Domestic Violence related information

_____ Date: _____
Client/Guardian Signature

_____ Date: _____
Witness