Boston Evening Therapy Associates, LLC

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL INFORMATION

Client's Name:_____ DOB: _____
(Print)

Client's Address:_____

(Street) (City) (State) (zip)

I hereby grant permission to: _____to Release/Request

the following information:_____

From/To: (Name)_____

(Street)_____

(City, State, Zip)_____

I am not giving permission for any redisclosure of this information other than as specified above.

I understand that I may revoke this consent at any time, except to the extent that action based on it has already begun. Revocation of this consent requires written notification. In any event, I request that this authorization to release information become invalid after _____ days from the date I sign it.

Having read or having had read to me and understood this form, I release my Boston Evening Therapy clinician and Boston Evening Therapy Associates, LLC from any liability arising from release of this information, providing the information is released in accordance with applicable law.

CLIENT'S/GUARDIAN'S SIGNATURE: _____DATE: _____

WITNESS SIGNATURE: _____ DATE: _____