Boston Evening Therapy Associates, LLC

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, PSYCHIATRIC, MEDICAL, AND/OR SUBSTANCE ABUSE INFORMATION

I , _____hereby give my consent to
(Name of client or guardian)

_____ of Boston Evening Therapy Associates, LLC,
(Name of clinician)

to release information from the medical record of:

Client's Name: _____ DOB: _____

Client's Address: _____

Regarding the mental health, psychiatric, medical, and/or substance abuse care given

from: _____ to _____

Specific information to be released:_____

_____

Release information to: _____

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 the 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:_____