BOSTON ABILITY CENTER

MAKING FUN AND FUNCTION GO HAND IN HAND

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

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: (____) ____-_____ Email address: _____

(2) Name: _____
Street Address: _____ Suite/Room #:___
City:_____ State:_____ Zip:_____
Telephone Number: (____) ____-_____ Email address: _____

(3) Name: _____
Street Address: _____ Suite/Room #:___
City:_____ State:_____ Zip:_____
Telephone Number: (____) ____-_____ Email address: _____

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)