HALLOWELL
BOSTON METROWEST

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AUTHORIZATION FOR EXCHANGE OF INFORMATION

To support evaluation/assessment
As part of your assessment, we would like to contact someone who knows you well. In order to do that, we need your permission. If you agree, please check and initial this paragraph, and complete the form below.

Initial__________

To support ongoing treatment
As part of your treatment at The Hallowell Center, we would like to stay in touch, when necessary, with the person(s) listed below. If you agree, please check and initial this paragraph, and complete the form below.

Initial__________

I hereby give my consent to the Hallowell Center Clinicians to exchange any information relating to my medical, educational, social and mental health history with:

1. Name: ____

   Address: ____

   Telephone: ____

2. Name: ____

   Address: ____

   Telephone: ____

____
Print Patient's Name

______/______/______
Date of Birth

____
Self/Parent/Guardian Signature

______/______/______
Date Signed

NOTICE: This document contains PRIVILEGED AND CONFIDENTIAL INFORMATION intended only for the person(s) named above. If you are not the intended recipient of this document, or the employee agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination or copying of this document is strictly prohibited. If you have received this document in error, please immediately notify us by telephone and return the document to us at the address at the top of the page, via the U.S. Postal Service. This statement is in accordance and compliance with the Health Insurance Portability and Accountability Act (HIPAA). Thank you.