HALLOWELL
BOSTON METROWEST
144 North Road, Suite 2450, Sudbury, MA 01776
p: 978-287-0810 | f: 978-287-5566

AUTHORIZATION FOR RELEASE OF INFORMATION

This form, when completed and signed by you, **authorizes The Hallowell Center to release protected information** to the following person:

Name: _____

Address: _____

Phone: _____

Please describe the information that you want released. Please be as specific as possible:

Please complete the following statement: I am requesting that The Hallowell Center release this information for the following reasons ("*at the request of the individual*" is all that is required if you do not desire to state a specific purpose):

Please complete the following statement: This authorization shall remain in effect until (*fill in expiration date*):_____, or until (*fill in an event that relates to the individual or the purpose of the release of information*):

HALLOWELL
BOSTON METROWEST
144 North Road, Suite 2450, Sudbury, MA 01776
p: 978-287-0810 | f: 978-287-5566

You have the right to revoke this authorization at any time, by written notification to The Hallowell Center. However, your revocation will not be effective to the extent that we have already taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

By signing below, I indicate that I understand and accept that The Hallowell Center generally may not condition services upon my signing an authorization unless the services are provided to me for the express purpose of creating health information for a third party. **I further indicated that I understand and accept** that information used or disclosed pursuant to this authorization may be subject to re-disclosure by he recipient of that information no longer protected by the HIPA (Health Insurance Portability and Accountability Act) Privacy Rule.

_____ _____/_____/_____

Patient's Name (Please Print) *Date of Birth*

_____ _____/_____/_____

Signature of Patient or Parent / Guardian *Date Signed*

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided below.