DELPHI CENTER OF QUINCY, INC.
DBA MASS BAY COUNSELING
234 COPELAND ST., 3RD FLOOR
QUINCY, MA 02169
TELE: (617) 786-0137
FAX: 617-479-4798

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

1. I, _____ DATE OF BIRTH _____
hereby authorize and request Mass Bay Counseling (M.B.C.) and the clinician (s) performing services on behalf of M.B.C. to:

_____Disclose Information to: And/Or _____Obtain Information from:

_____
(NAME OF INFORMATION SOURCE)

_____ _____
(ADDRESS) (PHONE NUMBER)

2. The specific Information to be disclosed is:
___Summary of Outpatient Treatment
___Laboratory Reports
___Medical Examination
___Alcohol and/or Drug Treatment
___Other (specify)_____
___Psychological or Educational Testing
___Discharge Summary
___School Records
___Legal Records

3. The purpose of such disclosure is:
___to permit continuity of care
___to permit case management (including reimbursement determinations) and processing of benefit claims
___to enable my employer to make a determination on my employment status (including disability leave)
___other (specify)_____

4. The form in which information should be released: __VERBAL __WRITTEN __PHOTOCOPIED __OTHER_____

5. I have carefully read and understand the above statement and do herein expressly voluntarily consent to disclose of the above information and/or medical/psychiatric records, including Alcohol and Drug abuse records of my condition, if relevant, to those person and/or agencies named above. I understand I may revoke this consent at any time unless action based on it has already begun. If I do not revoke it, this release will expire on _____ (less than 6 months) or six months from date below.

6. I hereby hold harmless the above-named professionals from any liability relevant to the release of the confidential information or privileged communication.

_____ _____
SIGNATURE OF PARENT/CLIENT SIGNATURE OF PARENT, GUARDIAN, CONSERVATOR OR REPRESENTATIVE (WHEN REQUIRED)

_____ _____
Witness Date

AM/6.2015