DELPHI CENTER OF QUINCY, INC.
DBA MASS BAY COUNSELING
21 MAYOR THOMAS MCGRATH HIGHWAY
SUITE 202
QUINCY, MA 02169
PH: (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 of 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 ___PHOTOCOPIED
___WRITTEN ___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 persons 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 six months) or six months from the 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