THE BAKER CENTER
FOR CHILDREN AND FAMILIES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client's Name: _____

Another name by which
Client may have been known: _____

Date of birth: _____

Parents/Caregivers name(s) (if client was a minor during treatment):

_____

Address at the time of treatment: _____

_____

Current Address (if different than above):

_____

_____

I, _____ hereby authorize Judge Baker Children's Center, dba The Baker Center for Children and Families, 53 Parker Hill Ave., Boston, MA 02120, to release information to:

_____

_____

For the purpose (s) of: _____

Portion of record to be released: (check those that apply)

- ☐ Diagnostic evaluation
- ☐ Psychological test report
- ☐ Student Records / Transcript
- ☐ Telephone contact
- ☐ Other: _____
- ☐ Summary of contact with client
- ☐ Mental health treatment records
- ☐ HIV testing or treatment

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I understand the following:

- Why the information is needed, and I am satisfied that it will be held confidential.
- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.

Client's signature: _____ Date: _____

If client is a minor, legal custodian's signature: _____ Date: _____

Legal custodian's name/ Relationship to client: _____

Witness Name & Signature: _____ Date: _____
(REQUIRED)

53 Parker Hill Ave
Boston, MA 02120

(617) 232-8390
bakercenter.org