Boston Child Study Center

Expert Mental Health Treatment, Training, & Research

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I, ______________________________, authorize clinical communication between Boston Child Study Center staff and:
(Name of Parent/Guardian/Self if 18+)

Provider:	Name/Address:	Phone:
PCP/ Pediatrician	____	(_______)__________________
	____	
Psychiatrist	____	(_______)__________________
	____	
Individual Therapist	____	(_______)__________________
	____	
Family Therapist	____	(_______)__________________
	____	
School	____	(_______)__________________
	____	
Case Manager	____	(_______)__________________
	____	
Other ( )	____	(_______)__________________
Other ( )	____	(_______)__________________

Communication may include any and all information in their possession acquired in the course of evaluation and/or treatment of the above named child/adolescent/patient. In addition, I authorize the staff of the Boston Child Study Center to share information with any emergency care givers who are involved in the care of my child in the event of a medical or psychiatric emergency. This authorization is voluntary and I have the right to refuse to sign it. I may revoke this authorization at any time by providing written notice of revocation; however such revocation would not affect any action taken by the Boston Child Study Center in compliance with this authorization before receipt of my written, hard-copy, revocation. You may accept photocopies or facsimiles of this authorization.

____   ____________________________
Signature of Parent / Guardian / Self (if 18+)   Date   Relationship to Child

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