Authorization to Communicate Health Information

Belmont Cambridge Health Care

Ph: 617-491-5111 Fax: 617-491-5222

Patient Information

Last Name:_____

First Name_____

Date of Birth:_____

Address:_____ Apt#:_____

City:_____ State:_____ Zip:_____

I authorize **Belmont Cambridge Health Care including the providers, staff or nurses** to disclose my child's health information excluding the following below.

Name:_____

Phone:_____

Relationship:_____

Name:_____

Phone:_____

Relationship:_____

The following categories of information **will not be released** unless I indicate my authorized by initialing next to the corresponding category(ies):

Adoption_____ Mental Health_____

Drug Treatment_____ Alcohol Treatment_____

Genetic Test Results_____

Termination of pregnancy_____

Sexually Transmitted diseases_____

HIV Testing/Treatment Records_____

This authorization will only last from:

Date:_____to _____

Or

Indefinitely (please circle)

Acknowledgment

This approval will remain in effect until the patient leaves Belmont Cambridge Health Care unless otherwise indicated by patient and/or parents/guardians from above.

Signature of parent/guardian, or patient if over 18:

_____

Date: _____