AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____

Parent/Guardian's Name: _____ Parent/Guardian's Address: _____

I (parent/guardian) request and authorize _____ to release healthcare information of the patient named above to:

Name: Bridget Brigade Foundation, Inc.

Address: 9 Emerson Rd.

City: Winchester State: MA Zip Code: 01890

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Parent/Guardian's Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER DATE SIGNED.