345 Boston Post Road
Sudbury, MA 01776

Tel. (978) 443-9200
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ERIKA L. FRANCIS-RANIERE, PH.D.

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: _____ DOB: _____
Address: _____ SSN: _____
_____

INFORMATION RELEASED *TO* DR. FRANCIS-RANIERE

I hereby request that _____ release the following information
_____
_____

to Dr. Erika Francis-Raniere at the above address and phone number:

___Hospital Admission Summaries
___Hospital Medical History and Physical Exam
___Neurological Consultation
___Outpatient Mental Health Evaluation and Treatment
___Telephone Consultation Regarding Past or Current
___Medical or Mental Health Evaluation/Treatment
___Hospital Discharge Summaries
___Records of Medical Evaluation and Treatment
___Records of Core Evaluation
___Most Recent Physical Exam and Laboratory Reports
___Psychological, Neuropsychological, Developmental, or Academic Testing Reports
___Other: _____

INFORMATION RELEASED *BY* DR. FRANCIS-RANIERE

I hereby request that Dr. Erika Francis-Raniere release the following information to
_____
_____
_____

___ Telephone Consultation Regarding Past or Present Mental Health Evaluation or Treatment
___Outpatient Mental Health Evaluation and Treatment
___Other: _____

I understand that once Dr. Francis-Raniere discloses my health information to the recipient, she cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this authorization at any time for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my treatment with Dr. Francis-Raniere; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization in which case Dr. Francis- Raniere may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires (one year from the date signed) or until I provide a written notice of revocation to Dr. Francis-Raniere at the above address. The revocation will be effective immediately upon Dr. Francis-Raniere's receipt of my written notice, except that the revocation will not have any effect on any action taken by Dr. Francis-Raniere in reliance on this Authorization before she received my written notice of revocation.

I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records, including Alcohol and Drug Abuse records, if relevant, to/by those persons/agencies named above.

_____ _____ _____ _____
Signature of Patient Date Signature of Patient *(if 2 patients)* Date

_____ _____ *Relationship to Patient: ___Mother ___Father ___Other
*Signature of Parent or Guardian Date If Other, please clarify: _____

*Note: Parent only may sign for patient 15 years old or under. Patient and parent must sign for patient 16-17 years old.