

AGINGWELL ADULT DAY HEALTH CENTER

420A Maple Street Unit 25

Marlborough, MA 01752

Tel. 508-485-7700 / F. 508-485-7702

CLIENT AUTHORIZATION FOR USE AND/OR DISCLOSURE OF HEALTH INFORMATION

I authorize AgingWell Adult Day Health Center to

Obtain From _____

Release To _____

Information and records relating to the care of:

Last Name: _____ First Name: _____

Address: _____

Date of Birth _____ Date(s) of Service: _____

Information Requested:

All Medical Records

Admission Summary

Psychological Assessments

Consults

History & Physical

Psychological Summary

D/C Summary

Other: _____

For the Purpose of: _____

This document to remain in effect until ____/____/____. I understand I can revoke this authorization at any time by contacting AgingWell Center in writing.

I understand that my record may contain information in reference to treatment for substance abuse and/or alcohol abuse, psychiatric treatment, or sensitive information. I agree to this release.

Signature: _____
Patient/Legal Guardian – Relationship

Date: _____

Witness: _____

Date: _____