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: ______________________

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☐ All healthcare information

☐ Other: ____

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

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER DATE SIGNED.