deborah farber, aprn

Request For Release Of Information

Health Provider Information:

Provider Name: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone Number:_____

Patient Information:

Patient Name: _____ Date Of Birth: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone Number:_____

I authorize _____ to release medical information that might relate to my mental health and/or substance abuse treatment to my mental health provider, Deborah Farber APRN.

Patient Signature: _____ Date: _____

The above authorization is subject to revocation by the patient at any time.
If not revoked, it shall remain in effect for one year from the date signed above.

Deborah Farber, APRN 175 Derby Street Suite 7 Hingham, MA 02043 781-749-9227