DEBORAH FARBER, APRN

Lauren Wilson, PMHNP-BC

Primary Care Physician Release of Information

Primary Care Physician Name: _____

Name of Facility Where You Receive Care: _____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone #:_____ Fax #: _____

Patient Information

Patient Name: _____ Date Of Birth:_____

Address:_____

City: _____ State:_____ Zip Code:_____

Patient Phone Number: _____

I authorize _____ to release my medical records to mental health providers, Deborah Farber, APRN and Lauren Wilson, PMHNP-BC.

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.

175 Derby Street Suite 7 Hingham, MA 02043 781-749-2278

DEBORAH FARBER, APRN

Lauren Wilson, PMHNP-BC

Medical Specialist Release of Information

Specialist Name: _____

Name of Facility Where You Receive Care: _____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone #:_____ Fax #: _____

Patient Information

Patient Name: _____ Date Of Birth:_____

Address:_____

City: _____ State:_____ Zip Code:_____

Patient Phone Number: _____

I authorize _____ to release my medical records to mental health providers, Deborah Farber, APRN and Lauren Wilson, PMHNP-BC.

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.

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DEBORAH FARBER, APRN

Lauren Wilson, PMHNP-BC

Behavioral Care Release of Information

Behavioral Specialist Name: _____

Name of Facility Where You Received Care: _____

Address:_____

City: _____ State:_____ Zip Code:_____

Phone #:_____ Fax #: _____

Patient Information

Patient Name: _____ Date Of Birth:_____

Address:_____

City: _____ State:_____ Zip Code:_____

Patient Phone Number: _____

I authorize _____ to release my behavioral health records to mental health providers, Deborah Farber, APRN and Lauren Wilson, PMHNP-BC.

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.

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