Authorization for Communication
For over 18- family or friend

Metro West Center For Well Being
142 Exchange Street
Millis, MA 02054

Dear Dr. Mathieu Bermingham,

I, _____, hereby give authorization for
Patient name
_____ to be involved in my treatment here.
Name/relationship

Communication may include appointment times/dates, medications, side effects, professional letters/forms and any other necessary information regarding my care and treatment between the above named person, yourself and staff.

I understand I may withdraw my permission in writing, whenever I choose.

Sincerely,

_____ _____
Signature of patient over 18 years old Date