Authorization to Exchange Medical Information

Metro West Center For Well Being, LLC 142 Exchange Street

Millis, MA 02054

Phone (508)376-6018

Fax (508)376-6070

I, _____ hereby authorize

Name of client

Mathieu Bermingham, MD to exchange information with

_____

Name of clinician

_____

Phone number, address and/or email address of clinician

Regarding mental health and other types of services being provided, the client's social and emotional functioning, and any medical issues pertaining to mental health. This information is for the purpose of treatment planning and evaluation, and the comprehensive coordination of care.

I understand this authorization expires one year from the date it was signed, unless revoked in writing prior to its expiration date.

_____

Signature of authorizing party Date