



## Release of Information

I hereby authorize the PANS Center and its employees to exchange medical information regarding the care of:

Patient Name: \_\_\_\_\_

Date-of-Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_

With:

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_

Phone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ Fax: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

To include: \_\_\_\_\_

I give permission to those listed above to exchange information about my medical history. This includes diagnosis and/or treatment for mental health or psychiatric conditions. This is to enable the sharing of information among those involved in my care.

If there are any limitations on this release of information they are written here: \_\_\_\_\_

I understand that I may revoke any portion of this Consent at any time by writing to The PANS Center at 100 Pond St. #18, Cohasset, MA 02025, or by email at [admin@panscenter.org](mailto:admin@panscenter.org). I understand that the revocation will not affect any action taken by The PANS Center in reliance on this Consent before written notice of revocation is received by The PANS Center.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Patient \_\_\_ Parent \_\_\_ Guardian \_\_\_  
(check one)

NOTE: If the patient is less than 18 years old this authorization must be signed by a parent or legal guardian. If the patient is 18 or older this authorization must be signed by the patient or a legal guardian.

Revision Date: 8/6/2024

857-344-0820

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[admin@panscenter.org](mailto:admin@panscenter.org)