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Section C: Must be completed for ALL authorizations:

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ___/___/____. Initials _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. Should I do so, this action will not have any affect on any actions taken by the providing organization before they received the revocation. Initials _____

X

Signature of patient or patient's representative

Date

Printed name of patient's representative: _____

Relationship to the patient: _____

*****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*****

This form may not be use to release information for treatment or payment except when the information released is psychotherapy notes or certain research information.