



Braintree Rehabilitation Hospital
250 Pond Street, Braintree, MA 02184
781-348-2500

Consent for Care and Treatment

I _____ hereby voluntarily authorize Braintree Rehabilitation hospital to perform outpatient diagnostic evaluation(s) and/or procedure(s) and to administer such outpatient therapy treatment(s) that in the opinion of the physician and consulting allied health personnel is/are necessary and appropriate.

Initials _____

Complaint / Grievance Procedure

The patient shall be fully informed of the hospital's Complaint/Grievance Procedure at the time of admission as well as receiving a copy of the procedure. The undersigned acknowledges a receipt of this information.

Initials _____

The above has been read and/or explained to me. I UNDERSTAND MY RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ, OR HAVE HAD READ TO ME, THIS FORM.

Patient/Guardian or Responsible Party

Date



AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
Braintree Rehabilitation Hospital
250 Pond Street, Braintree, MA 02184
Phone: 781-348-2120; Fax: 781-848-5821

1. Patient Information

Patient Full Name:
Patient Address: City, ST, Zip:
Date of Birth: Phone #:
Other Name During Treatment?

2. Release Information To

-This Box Must Be Complete In Order For Request To Be Processed-

Name: Patient, see above box for patient name, address etc...

3. Information to be Released

[X] School Sports Physical conducted on
Please list date

4. Authorization to Release Sensitive Information

Required - Please complete the check boxes and initial lines below indicating how sensitive information should be handled.

Check One Initial each line below
I DO DO NOT N/A want information about Mental Health released
I DO DO NOT N/A want information about HIV/AIDS Information released
I DO DO NOT N/A want information about Alcohol/Substance Abuse released
I DO DO NOT N/A want information about Other sensitive info released



Please confirm that you have put a checkmark and initialed all the sensitive information categories above regardless if they are applicable or not. If this box is incomplete or if sensitive information is not initialed, we may be unable to fulfill this request.

I understand this authorization expires 90 days after discharge from the current course of treatment or by the date listed below:

Specific Expiration date if other than 90 days after the current course of treatment

- I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do revoke, it would not have any effect on information released by the hospital before it received the revocation.
I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to the protections of the privacy standard.
I understand that my treatment or continued treatment by Five Star Quality Care, Inc. and its affiliates is not conditioned on whether or not I sign this authorization. I know that I may refuse to sign this authorization.
I understand that release of my information to Five Star Quality Care, Inc. or its use by Five Star Quality Care, Inc. for marketing purpose(s) may result in direct or indirect remuneration to Five Star Quality Care, Inc.

Signature Date

(Patient/Legal Guardian)

Legal Guardian: Request is only valid if documentation is attached that validates your authority.