BRIDGES
THERAPY AND WELLNESS CENTER

COMPREHENSIVE PSYCHOTHERAPY, PSYCHIATRIC, AND TESTING SERVICES

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

RE: _____ DOB: _____

I hereby authorize the employees of **Bridges Therapy and Wellness Center** to release information to and/or receive information from:

_____
Name of Person, Organization or Institution

_____
Address and Contact Information

The specific type of information to be disclosed:

☐ Medical Records
☐ Psychiatric Records
☐ Psychological Records
☐ Academic Records
☐ School Personnel Reports
☐ Behavioral Report
☐ Financial Information
☐ Legal Information
☐ Insurance Information
☐ Other Information (specify)
_____

For the purpose of: _____
Release is valid for: ☐ One Year ☐ Termination of Treatment ☐ Specific Dates: _____

- I understand my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- I understand that I may revoke this authorization at any time by providing written notice to Bridges Therapy and Wellness Center, but I agree my authorization to release information shall remain in effect until the date the revocation is stamped as received by Bridges Therapy and Wellness Center, and that any documents released previous to that date are considered to be authorized and approved by me.
- I understand that I have a right to a copy of this signed authorization and that I must request a copy be provided to me. I understand I am not required and cannot be forced to sign this authorization of release of confidential information.
- I understand the information will be released by phone, fax, mail or e-mail. My signature indicates my agreement to any method of disclosure. I understand information shared electronically may not be secure and confidentiality is not ensured.

_____ _____
Signature of Client or Parent/Guardian* Date

**Once uploaded, to e-sign DO NOT click the button asking if you have physically signed the form.*