

## AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

RE: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Name Here

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, and Their Relationship to the Client

\_\_\_\_\_  
Email Address, Phone Number, Address, and Other Contact Information

The specific type of information to be disclosed:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> All Information                    | <input type="checkbox"/> Academic Records         | <input type="checkbox"/> Financial Information |
| <input type="checkbox"/> Medical Records                    | <input type="checkbox"/> School Personnel Reports | <input type="checkbox"/> Legal Information     |
| <input type="checkbox"/> Psychiatric Records                | <input type="checkbox"/> Behavioral Report        | <input type="checkbox"/> Therapy Portal        |
| <input type="checkbox"/> Psychological Records              | <input type="checkbox"/> Insurance Information    | <input type="checkbox"/> Appointment Reminders |
| <input type="checkbox"/> Other Information (specify): _____ |   |  |

For the purpose of: \_\_\_\_\_

Release is valid for:  One Year  Termination of Treatment  Specific Dates: \_\_\_\_\_

- If Therapy Portal is selected above, I understand that the individual to whom I am releasing my information to will be able to view, access, and complete Intake Forms, Billing Information (Superbills/Statements), Scheduled Appointments & other Records. Unless requested, this excludes Progress Notes and specific details discussed in sessions.
- 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, portal, 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.*