Bridge Counseling Group

Release of Information

I, _____ , _____
Name of client Date of Birth

Hereby Authorize _____/Bridge Counseling Group
Name of Intended Releaser/Release

☐ To Obtain From: _____
Name of Person Holding Information

_____
Company/Business Name Address/Phone

☐ Release to: _____
Name of Person Receiving Information

_____
Company/Business Name Address/Phone

The following information:

__ Entire record
__ Diagnosis
__ Individual Treatment Plan
__ Treatment Summary
__ Telephone Conference
__Results of Psychological and/or Vocational Testing (Incl Raw Data)
__ Psychiatric Evaluation
__ Neurological Assessment
__ Legal Information
__ Discharge Summary
__ Medical Information, Lab Test Results
__Other

For the purpose of evaluation and/or treatment planning.

The above information may be exchanged orally and/or in writing. This authorization is given of my own free will and is in effect for 90 days from the date below. I understand that I can revoke this authorization in writing at any time.

Signature: _____ Date: _____

Witness: _____