BRIDGMAN
PSYCHOLOGICAL SERVICES. P. C.

Release of Information

Patient: _____
Address: _____
City/State/ZIP: _____

I authorize:

_____
Name

_____
Company/Organization

_____
Address

_____
City/State/ZIP

_____
Phone

to release my medical records to:

Laird Bridgman, Psy.D., C.E.A.P.
22792 Centre Drive, Suite 290
Lake Forest, CA 92630
949-707-6633 ph
949-770-5433 fx
docbridgman@sbcglobal.net

The information to be released is limited to the following information:

_____

_____

_____

_____

Or ❑ No limitations (if checked).

This release will expire on _____/_____/_____.

_____
Client or responsible party

_____
Date