Release of Information

Patient: ____
Address: _______________________________________
City/State/ZIP: __________________________________

I authorize:

____
Name

____
Company/Organization

____
Address

____
City/State/ZIP

____
Phone

to release my medical records to:

Shari Bridgman, Ph.D.
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