Release of Information

Patient: ____________________________________
Address: ___________________________________
City/State/ZIP: ______________________________

I authorize Laird Bridgman, Ph.D. to release my medical records to the following:

____
Name
____
Company/Organization
____
Address
____
City/State/ZIP
____
Phone

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