



Release of Information

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

I authorize Shari 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