BRIDGMAN
PSYCHOLOGICAL SERVICES. P. C.

Release of Information

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

I authorize _____ AND:

_____
Name

_____
Company/Organization

_____
Address

_____
City/State/ZIP

_____
Phone

To mutually exchange my medical records in their possession.

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

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