BRIDGES COUNSELING
CENTER FOR CHILD & FAMILY WELLNESS

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth:_____

I request and authorize Bridges Counseling to release healthcare information regarding the above named to:

FACILITY:_____
(Hospital, School, Doctor, etc.)

NAME:_____
TITLE:_____
FAX:_____
EMAIL:_____

This request and authorization apply to:

- □ Discharge Summary
- □ History & Mental Exams
- □ Progress Notes
- □ Emergency Reports
- □ Consultations
- □ Outpatient Records
- □ Billing Statements
- □ Substance Abuse Evaluation, Report
- □ Other(Explain)_____

Specify Date or Time Period for Information Selected Above: _____

Specific Authorizations

The following information will not be released unless you specifically authorize it by marking the relevant box(es):

- □ I specifically authorize the release of information pertaining to drug and alcohol abuse diagnosis and /or treatment.
- □ I specifically authorize the release of information pertaining to mental health diagnosis and /or treatment.

The purpose of this release is (check one or more):

- □ Continuity of care or discharge planning.
- □ Billing and payment of bill.
- □ At the request of patient or patient representative.
- □ Other (explain)_____

NOTICE: *Bridges Counseling and many other organizations and individuals such as physicians, hospitals, and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.*

My Rights:

- I understand this authorization is voluntary and that treatment may not be conditioned on signing authorization.
- I may revoke this authorization at any time.
- I am entitled to receive a copy of this Authorization

Expiration of Authorization: Unless otherwise revoked, this authorization expires in 12 months. If no date is indicated, this authorization will expire 12 months after the date of signing this form.

_____

Signature of Patient or Patient's Legal Representative **Printed Name** **Date/Time**

_____

If signed by someone other than patient, state your legal relationship to patient

_____

Witness **Title** **Date/Time**