Authorization to Release Information

**Ronald F. Bridges, M.A. M.A.C.E.**

**Licensed Marriage and Family Therapist # 79596**

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**Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize Ron Bridges, Licensed Marriage & Family Therapist # 79596 to release or exchange

the following information with/to**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

This information is otherwise confidential and its use is limited specifically to the treatment

of the above client. The information authorized for release is indicated by a YES or NO..........

\_\_\_\_\_\_\_ Police, Court reports or Probation

\_\_\_\_\_\_\_ Social or Behavioral Functioning

\_\_\_\_\_\_\_ Results of Drug/ Alcohol Testing

\_\_\_\_\_\_\_ Medical History including any Physical Exam results

\_\_\_\_\_\_\_ Educational Functioning and Testing

\_\_\_\_\_\_\_ Psychological and/or Psychiatric Testing or Assessment results

\_\_\_\_\_\_\_ Clinical Treatment Records and/or Summary Reports

\_\_\_\_\_\_\_ Family of Origin Background and History

This consent is valid immediately as of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.It is valid for two years or until

Treatment is terminated and may be rescinded at anytime. A Photocopy of original is valid.

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_