



The Bridges Program Confidential Consent for Release of Information

This form allows The Bridges Program to receive and release information as it relates to services pertaining to the following client.

Client Name: _____

SS #: _____ Client Date of Birth (MM/DD/YYYY): _____

Agency, entity, and/or individual(s) that can receive information pertaining to the client:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

What information can Bridges share with the above agency, entity, or individual(s):

This consent shall remain valid for a period of twelve (12) months, unless revoked earlier by me in writing. I understand that I may withdraw this consent at any time. I further acknowledge that the information described above may be confidential, privileged, or otherwise protected from disclosure under applicable federal and state laws.

Client/Guardian Print Name: _____ Date: _____

Client/Guardian Signature: _____ Date: _____

Bridges Witness: _____ Date: _____