The Bridges Program

CONFIDENTIAL CONSENT FOR RELEASE OF INFORMATION

This form allows The Bridges Program to receive or release information pertaining to the following client:

Client Name: _____

SS#: _____ Client DOB: _____

Agency or entity to release or receive information pertaining to the client:

_____

_____

Phone: _____

Specific Information to be released/received:

_____

_____

This consent is valid for a period of 12 months. I understand I may revoke this consent at any time, except to the extent that action would have already taken place prior to my revocation. I understand that the above information may be confidential, privileged, or otherwise protected from disclosure according to Federal and state laws.

Client signature: _____ Date_____

Parent or Guardian: _____ Date_____

Staff Witness: _____ Date_____