



Doreen Bridgman MS,CCC,SLP
2362 Apple Ridge Circle
Manasquan, NJ 08736
doreen@thecognitivecoach.net
732-977-7381

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____ MI ____ DOB: __/__/__
Client Address _____
Client Home Phone: _____ Cell/Work Phone: _____
Client Email Address: _____

Recipient Information

I, _____, do hereby authorize _____ to release a copy of my mental health information to the person or facility below. Name of person/facility to receive medical information: _____ Phone: _____
Address: _____
Date of Authorization: __/__/__ Authorization to expire on __/__/__ or upon the happening of the following event: _____

Information to be released

My treatment plan and progress notes
 Only those portions pertaining to: _____
 Other: _____

Purpose of Information Release:

Treatment planning
 Other (specify): _____

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature _____ Date _____

(a) Print your name: _____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: minor parent legal guardian