AustinOCD Bruce Mansbridge, PhD, Licensed Psychologist PLLC

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Authorization to Release Confidential Records and Information

Name of patient: ____ Date of Birth: __________________

I/We hereby authorize Bruce Mansbridge, PhD to release any and all records relating to the above-named individual to the following person(s) or facility:

____

Address: ____ Phone: ________________________

____ Fax: ___________________________

This authorization covers ALL records and ALL dates.

This form also authorizes discussions of any aspect of this patient's case between the above-named person(s) or facility and Bruce Mansbridge, PhD. This specifically includes information transfer in both directions.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

____ __________________________

Signature of patient Date

_______________________________ __________________________ _____________ _____________

Signature of parent/ guardian/representative | Printed name | Relationship | Date

Rev. 9/2018