

David M. Dunning, LMFT
Bridges Counseling Center
A Joint Venture
9253 Sierra College Blvd, Suite 100
Roseville, CA 95661

RELEASE OF INFORMATION

Client Name _____ **DOB** _____

Please sign the statement below giving your permission for David M. Dunning, LMFT to communicate with the following individual, agency, or insurance companies on your behalf:

(Name of individual or group to be contacted)

Located at: _____
(Address, city, state, zip)

Phone: _____

I authorize: **David M. Dunning** to release and/or exchange the following clinical information pertaining to my treatment:

- | | | |
|---|---|---|
| <input type="checkbox"/> Intake Summary | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> IEP |
| <input type="checkbox"/> Aftercare Plan | <input type="checkbox"/> Educational Testing | <input type="checkbox"/> Social History |
| <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Psychological Evaluation | |
| <input type="checkbox"/> Treatment or Closing Summary | <input type="checkbox"/> Treatment Plan | |
| <input type="checkbox"/> Academic/Cumulative File | <input type="checkbox"/> Other: | |

The purpose for the release of this data shall be:

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Further mental health/psychological/psychiatric care | <input type="checkbox"/> Research |
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Other: |

This authorization to release or obtain information from my records and its implications are fully understood, and is made voluntarily on my part. This consent will expire after one (1) year from the date on which it was signed. I agree that a photocopy of this release form is acceptable but must be individually signed by the releaser, and me and understand I have the right to receive a copy of this authorization upon my request. I understand that I have the right to rescind this release at any time with written notice to my provider.

Signature of Patient, Parent or Guardian

Printed Name

Date

Relationship to patient:

- Self
- Parent / Guardian
- A person legally authorized to act in the behalf of the patient

I have discussed the above issues with this person and have, based on my observations or behavior and responses, no reason in my professional judgment, to believe that this person is not fully competent to give consent, informed and voluntarily.

Signature of Provider

David M. Dunning
Printed Name

Date