David M. Bradley, LMFT

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Authorization to Release/Obtain Information

Patient Name: _____ Birth date: _____

Maiden or other name (if applicable): _____

I give my authorization for David M. Bradley, LMFT to (check one):

___ share information with
___ receive information from
___ share information with and receive information from the following persons:

_____

_____

_____

_____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request.

I understand that my express consent is required to release any information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

Signature (patient or authorized representative): _____

Date: _____

Relationship/authority (if signed by authorized representative): _____

I have received a copy of this signed authorization: (please initial) ____ yes ____ no