BRIDGEPOINT

Arun K. Kantamneni, MD, Psychiatrist
Darshan A. Patel, MD, Psychiatrist

AUTHORIZATION TO OBTAIN AND/OR RELEASE INFORMATION

I,_____, hereby authorize Bridgepoint Clinic to release and/or obtain information from the records of _____ (DOB:_____) for the purpose/s of:

1. Psychiatric Evaluation _____
2. Medication Evaluation _____
3. Ongoing Treatment _____
4. Insurance Request/Claims _____

The information to be released and/or obtained includes all or some of the following:

1. Communication and information provided from one of your existing medical providers
2. Psychological Testing Reports
3. Medical/Surgical Records
4. School Records
5. Lab/Imaging Reports
6. Juvenile Court Records
7. Other social agency reports

Release/Obtain information to/from:
Name _____
Address _____
Telephone and Fax _____

PLEASE FORWARD INFORMATION TO THE ATTENTION OF BRIDGEPOINT CLINIC.

Authorization will remain in effect for:
_____ One year or until and earlier date specified here: Date _____
_____ The time necessary to complete my treatment
_____ Duration of court mandate: Date _____

I understand that in order to protect confidentiality, my agreement to obtain and/or release information is necessary and this permission is limited for the purposes and to the person listed above. I also understand that unless otherwise limited by state or federal regulations (such as court mandate) I can cancel this consent at any time, except for action, which has already been taken.

Signature of Patient or Parent/Legal Guardian _____
Signature of Provider _____
Date _____