Don Baker, MA, LMHC
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Authorization for Release of Information

This form when completed and signed by you (signature below), authorizes the designated person or organization to release or obtain protected health information for the following person:

Client Name: _____

Date of Birth: _____/_____/_____

I authorize **Don Baker, MA, LMHC** to release the following information verbally and in writing to:

_____

Phone: (_____)_____ Fax: (_____)_____

(* Please initial below the information to be released)

_____ Screening Information _____Behavioral and Psychological Reports

_____ Treatment Plan _____Psychotherapy/Counseling Notes

_____ Other: _____

I authorize: _____ to release the following information verbally and in writing to **Don Baker, MA, LMHC**

(* Please initial below the information to be released)

_____ Screening Information _____Behavioral and Psychological Reports

_____ Treatment Plan _____Psychotherapy/Counseling Notes

_____ Other: _____

I am requesting release of this information for the following reasons:

(* Please initial below)!

_____ To provide services and care

_____ Other purpose (please specify):_____

This authorization shall remain in effect until (expiration date): _____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked this release shall remain in effect for the period reasonably needed to complete the request. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA privacy rule.

Date: _____/_____/_____

Signature of Client: _____

Printed Name of Client: _____