Don Baker, MA, LMHC
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Authorization for the Release of Confidential Information

I, ____, hereby authorize
(Client Name Printed)

Don Baker, MA, LMHC to release the following confidential information:
( ) Psycho-Social
( ) Drug / Alcohol Use Assessment and Evaluation
( ) Other (Specify) ____

regarding ____
(Client Name Printed)

from _________________________ to ________________________________
(Today's Date) (Date of Completion)

to____
(Name of Treatment Center, Therapist, Coach, Prescriber, Agency)

I understand that records are protected under confidentiality regulations, and any records that contain information regarding drug and / or alcohol abuse that are created by an alcohol abuse or drug abuse prevention program are protected under federal confidentiality laws (42 CFR Part 2) and state law.

I understand that said record about the diagnosis, treatment, or referral of alcohol and drug abuse problems cannot be disclosed without my written consent, and those receiving / this information are prohibited from re-disclosing these records unless expressly permitted by my written consent.

I understand that any record that contain information regarding HIV and / or confirmed STD test or treatment records cannot be disclosed without key written consent unless permitted by State law, and that those receiving this information are prohibited from re-disclosing these words without my further written consent.

I understand that I may revoke this consent at any time unless action has been taken in reliance on it. If not previously revoked, this consent will terminate in 90 days.

_______________________________ ___________________________
(Date of Authorization) (Client Signature in Full)