Baker Street
Behavioral Health

Authorization of Release of Information

I / We _____
Client Name/Parent or Guardian Name

hereby authorize Baker Street Behavioral Health/ _____
Clinician Name

To:

Release information to: Name: _____

Obtain information from: Phone: _____

Exchange information with: Fax: _____

The information requested or authorized for release or exchange pertains to:

Client Name: _____

Clinical information pertaining to treatment:

Other: _____

This authorization is valid through _____ or indefinitely _____ (initial). I may revoke this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the clinician/ group above indicating my desire to cancel. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I understand that my treatment provider generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

_____ _____
Client's Signature (if over 14 years old) Date

_____ _____
Parent/ Guardian's Signature Date