Kelley A. Baker PhD LPC

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Release of Confidential Information

I _____ hereby authorize Kelley A. Baker, Ph.D., and administrative staff to release information regarding the content of the sessions in which she has provided professional services for the following people. I also release the person(s) listed to provide Kelley A. Baker with information they have about any person listed below.

Parent_____ DOB_____

Child 1_____DOB_____

Child 2_____DOB_____

Child 3 _____DOB_____

To the following professional(s) at the corresponding address or phone number:

Attorney's Name _____ Phone #_____

Address (Physical & Email)_____

Child's Teacher Name _____ Phone #_____

Address (Physical & Email)_____

Name _____ Phone #_____

Address (Physical & Email)_____

Name _____ Phone # _____

Address (Physical & Email)_____

This form is for non-Hipaa protected health records. Please put counselors, medical providers, and other mental health professionals on the HIPAA Form.

I understand that I can revoke this consent at any time in writing, except to the extent that action has been taken in reliance of this consent prior to my revocation. I understand that this authorization will expire two years after the date of my signature, or, if not earlier revoked, it shall terminate on:

(Date or condition Release will Expire)

Client signature Date