

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 counseling or supervision 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.

_____ DOB _____
_____ DOB _____
_____ DOB _____
_____ DOB _____

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

Name _____ Address _____

Phone (office, fax) _____

Name _____ Address _____

Phone (office, fax) _____

Name _____ Address _____

Phone (office, fax) _____

Name _____ Address _____

Phone (office, fax) _____

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

Client signature

Date