Grace Duarte de Baker, LCSW

Licensed Clinical Social Worker
Psychotherapy for Adults, Children, Couples and Families.
(901) 245-2922

AUTHORIZATION TO RELEASE INFORMATION

Client Name: ____ DOB: _____/______/__________

With my signature below, I authorize **Grace Duarte de Baker, LCSW**
☐ *to OBTAIN* information from ☐ to *RELEASE* information to ☐ to *EXCHANGE* information with

Contact Person: __________________________________ Organization: ____________________________

Address: __________________________________ Telephone: _________________________

City, State, Zip: ___________________________________ Fax: _________________________

Information to be released/obtained or exchanged consists of mental health information including:

☐ Evaluation ☐ Treatment Plan ☐ Progress Notes ☐ Coordination of Care
☐ Other: __________

The purpose for the disclosure is:

☐ Coordination of Care ☐ Other:____________________________

I understand that additional laws about mental health, HIV/AIDS, genetic, and alcohol/drug treatment information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space.

Initial: _____ Mental health information
Initial: _____ Drug/alcohol diagnosis, treatment, or referral information
Initial: _____ HIV/AIDS information
Initial: _____ Genetic testing information

Other information

I understand that I am not required to sign this authorization. If I refuse to sign this, it will not prevent me from getting mental health or drug/alcohol treatment from Grace Duarte de Baker, LCSW. The only exception is if the services I am seeking are only for providing health information to someone else and this authorization is needed to make the disclosure.

I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed for the reasons described here. If Grace Duarte de Baker, LCSW has already used or disclosed information, that cannot be undone. To revoke this authorization, I can request the form and return to my provider.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

Unless revoked, this authorization expires 60 days after the completion of treatment or:
____

I have read this authorization and understand it.

Client signature: ___________________________________ Date:______________

Parent/Guardian/Representative signature: ___________________________________ Date:______________

Relationship to client: Parent Legal guardian Power of Attorney/Healthcare Other______________